Supreme Court, U.S.
FILED
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(18) (17)

Nos. 02-1845 & 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,

Petitioner,

v.

RUBY R. CALAD, *et al.*,

Respondents.

On Writs Of Certiorari
To The United States Court Of Appeals For The Fifth Circuit

JOINT APPENDIX

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CERTIORARI GRANTED NOVEMBER 3, 2003

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7/11/01	Private civil federal case docketed. NOA filed by Appellant Juan Davila. [01-10905] (trm) [01-10905]
8/27/01	Appellant's Brief filed by Appellant Juan Davila. Copies of brief: 7 # of pages: 60. Word count: 13,958 Disk Provided [Y/N]: y Date of COS: 8/27/01 Sufficient [Y/N]: y [01-10905] A/Pet's Brief ddl satisfied. E/Res's Brief due on 9/26/01 for Aetna US Hlthcare N, for Aetna US Hlthcare. (dsb) [01-10905]
8/27/01	Record excerpts filed by Appellant Juan Davila # of copies: 4 Sufficient [Y/N]: y. [01-10905] (dsb) [01-10905]
10/26/01	Appellee's Brief filed by Appellee Aetna US Hlthcare, Appellee Aetna US Hlthcare N. Copies of Brief: 7 # of pages: 49. Word count: 11,628 Disk Provided [Y/N]: y Date of COS: 10/25/01 Sufficient [Y/N]: y. [01-10905] E/Res's Brief ddl satisfied. Reply Brief due on 11/9/01 for Juan Davila. (dsb) [01-10905]
11/14/01	Reply brief filed by Appellant Juan Davila. Copies of Brief: 7 # of pages: 29. Disk Provided [Y/N]: y Date of COS: 11/9/01 Sufficient [Y/N]: y. [01-10905] Reply Brief ddl satisfied. (jaa) [01-10905]
5/6/02	Oral argument heard. Case argued by George Parker Young for Appellant Robert Roark; Robert Roark, on behalf of the Estate of Gwen Roark in 01-10831, Robert N Eccles for Appel-

lee Humana HMO Texas Inc, Appellee Humana Health Plan, Appellee Humana Inc in 01-10831, George Parker Young for Appellant-Cross-Appellee Ruby R Calad in 01-10891, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Robert N Eccles for Appellee Cigna Healthcare TX in 01-10891, George Parker Young for Appellant Juan Davila in 01-10905, John Bruce Shely for Appellee Aetna US Hlthcare of North Texas, Appellee Aetna US Hlthcare in 01-10905, George Parker Young for Appellee Walter Patrick Thorn, Appellant-Cross-Appellee Ruby R Calad in 01-10943, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (pft) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Opinion filed. Issd in T form? Y Issue Mandate due on 10/8/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943 . [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Judgment entered and filed. [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

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9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 for rehearing en banc. # of copies filed: 20 [3830095-1] Sufficient Rehearing due on 10/11/02 for Aetna US Hlthcare N in 01-10891, for Aetna US Hlthcare in 01-10891, for Aetna US Hlthcare N in 01-10905, for Aetna US Hlthcare in 01-10905, for Aetna US Hlthcare N in 01-10943, for Aetna US Hlthcare in 01-10943. Sufficient [Y/N]: N Missing statement of facts. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/1/02 Petition filed by Appellee Cigna Healthcare TX in 01-10891 for rehearing en banc. # of copies filed: 20 [3831100-1]. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/2/02 Rehearing made sufficient by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in

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10/10/02 Petition filed by Appellant Robert Roark in 01-10831 for rehearing en banc. # of copies filed: 20 [3839307-1]. Submit Rehearing due ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

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1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc (3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (ksw) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant Juan Davila in 01-10905, Appellant-Cross-Appellee Ruby R Calad in 01-10943 to petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for

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11/4/02 Response/opposition filed by Appellee Humana Inc in 01-10831, Appellee Humana Health Pln TX in 01-10831, Appellee Humana HMO Texas Inc in 01-10831 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1]

by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y. [4006487-1] [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943. Sufficient [YIN]: Y [4006523-1]. [01-10831, 01-10891, 01-10905, 01-10943]

(mcs) [01-10831 01-10891 01-10905 01-10943]

11/5/02 Response/opposition filed by Appellee Cigna Healthcare TX in 01-10891 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y [4006951-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Aetna US Healthcare Inc and Aetna US Healthcare of North

Texas, Inc's petition for rehearing [3829883-1] in 01-10831, 01-10891, 01-10905, 01-10943, denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas Inc's petition for rehearing en banc [3830095-1] in 01-10831, 01-10891, 01-10905, 01-10943. With poll (Y/N)?: N. Issue Mandate due on 4/22/03 in 01-10831, in 01-10891, in 01-10905, in 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Robert Roark's petition for rehearing en banc [3839307-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943, denying Cigna Healthcare of Texas Incorporated's petition for rehearing en banc [3831100-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]

4/23/03 Mandate issued. Approved BOC Issued (Y/N)?: y [01-10831, 01-10891, 01-10905, 01-10943] Issue Mandate ddl satisfied. (wdc) [01-10831 01-10891 01-10905 01-10943]

Relevant Docket Entries in U.S. District Court for the Northern District of Texas, Case No. 4:00-cv-01855, *Davila v. Aetna U.S. Healthcare Inc.*

Filing Date	#	Docket Text
12/12/2000	1	NOTICE OF REMOVAL; Filing Fee $150.00 Receipt # 35250 (dld) (Entered: 12/13/2000)
12/12/2000	1	DEMAND for jury trial by plaintiff Juan Davila made in state court on 11/9/00 (dld) (Entered: 12/13/2000
12/12/2000	1	ANSWER to Complaint by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT made in state court on 12/01/00 (dld) (Entered: 12/13/2000)
01/25/2001	5	MOTION by plaintiff Juan Davila to remand (8pgs) (fba) (Entered: 01/26/2001)
01/25/2001	6	MEMORANDUM by plaintiff Juan Davila in support of [5-1] motion to remand (15+ pgs) (fba) (Entered: 01/26/2001)
01/25/2001	7	APPENDIX by plaintiff Juan Davila in support of [5-1] motion to remand (15+pgs) (fba) (Entered: 01/26/2001)
02/14/2001	9	RESPONSE and BRIEF by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT in opposition to plaintiff's [5-1] motion to remand (15+pgs) (fba) (Entered: 02/15/2001)

Filing Date	#	Docket Text
02/14/2001	10	APPENDIX by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT in support of [9-1] opposition response (15+pgs] (fba) (Entered: 02/15/2001)
02/28/2001	13	12(B)(6) MOTION with memorandum in support by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT to dismiss for failure to state a claim upon which relief can be granted (6pgs) (fba) (Entered: 02/28/2001)
03/09/2001	14	RESPONSE by plaintiff Juan Davila to [13-1] motion to dismiss for failure to state a claim upon which relief can be granted (15+pgs) (fba) (Entered: 03/09/2001)
03/09/2001	14	REPLY by plaintiff Juan Davila to Aetna's response to plaintiff's [5-1] motion to remand (fba) (Entered: 03/09/2001)
03/09/2001	15	Second APPENDIX by plaintiff Juan Davila in support of [5-1] motion to remand (15+pgs) (fba) (Entered: 03/09/2001)
03/30/2001	19	REPLY IN SUPPORT by defendant Aetna U.S. Healthcar, defendant Aetna U.S. Health NT to response to defendants' [13-1] motion to dismiss for failure to state a claim upon which relief can be granted (15+pgs) (fba) (Entered: 04/02/2001)

Filing Date	#	Docket Text
06/29/2001	25	ORDER denying [5-1] motion to remand, granting [13-1] motion to dismiss for failure to state a claim upon which relief can be granted . . . . Plaintiff's state-law is Dismissed With Prejudice to the refiling of same . . . . SEE ORDER FOR SPECIFICS . . . . (Singed by Terry R. Means) Copies to counsel: 06/29/01 Page(s) 6 (fba) (Entered: 06/29/2001)
06/29/2001	26	FINAL JUDGMENT . . . . Ordered that all claims are hereby Dismissed With Prejudice to their refiling; all costs of court under 28 U.S.C. 1920 shall be borne by Plaintiff. (Signed by Judge Terry R. Means) Copies to counsel: 06/29/01 Page(s): 1 (fba) (Entered: 06/29/2001)
06/29/2001	27	NOTICE OF APPEAL by plaintiff Juan Davila re [25-1] order, [26-1] judgment order; fee due; TO given; no hearing/trl held; cy to judge and all parties (2pgs) (fba) Modified on 07/02/2001)

Filing Date	#	Docket Text
04/25/2003	30	JUDGMENT/MANDATE of USCA #01-10905 as to 27 Notice of Appeal filed by Juan Davila . . . ordered and adjudged that the judgment of the DC is reversed, and the cause is remanded to the DC for further proceedings in accordance with the opinion of this Court. Further ordered that dft-appellees pay to pla-appellant the costs on appeal to be taxed by the Clerk of this Court. Issued as Mandate: 04/23/2003. (csw,) (Entered: 04/25/2003)
05/09/2003	33	FINAL JUDGMENT OF REMAND . . . In accordance with the opinion of the Fifth Circuit Court of Appeals, issued as mandate on April 23, 2003, and Federal Rule of Civil Procedure 58, ordered that all claims in this case are remanded to the 67th Judicial District Court of Tarrant Co Tx – copy to 67th JD Tarrant Co (Signed by Judge Terry R Means on 06/09/03) (wrb,) (Entered: 06/11/2003)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
v.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

PLAINTIFF'S BRIEF IN SUPPORT OF
MOTION TO REMAND

January 25, 2001

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ATTORNEYS FOR PLAINTIFF

* * * *

[Page 1]

FACTUAL AND PROCEDURAL BACKGROUND

Juan Davila[2]

Juan Davila obtained his Aetna HMO health coverage through his employer, Monitronics, where he screens house-signaled house alarms.[3]

* * * *

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2 The factual allegations concerning Mr. Davila are found in Plaintiff's Original Petition at ¶¶ 11-15; their legal effect is outlined in ¶¶ 17-21.

3 In Plaintiff's Original Petition, Mr. Davila is erroneously identified as a member of Aetna's PPO. Mr. Davila is a member of Aetna's HMO. *See* Appendix in Support of Plaintiff's Motion to Remand, Tab 13 (APP 066).

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
FILED
FEB 14 2001
CLERK, U.S. DISTRICT COURT
By /s/
Deputy

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
V.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
AND AETNA U.S.	§	
HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF RESPONSE AND BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION TO REMAND

John B. Shely
State Bar No. 18215300
ANDREWS & KURTH L.L.P.
600 Travis, Suite 4200
Houston, Texas 77002
713.220.4200
713.220.4285 (Facsimile)

David Broiles
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500 Main Street, Suite 1200
Fort Worth, Texas 76102
817.335.3311
817.335.7733 (Facsimile)

ATTORNEYS FOR AETNA U.S. HEALTHCARE, INC. and AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.

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Exhibit A Affidavit of Pamela H. Deveau

Exhibit 1 Group Agreement between Aetna and Monitronics International Inc.

Exhibit 2 Certificate of Coverage between Aetna and Monitronics

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JUAN DAVILA	§	
	§	
Plaintiff,	§	
	§	
V.	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
AETNA U.S.	§	
HEALTHCARE, INC.	§	
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HEALTHCARE OF	§	
NORTH TEXAS, INC.,	§	
	§	
Defendants.	§	

AFFIDAVIT OF PAMELA H. DEVEAU

COUNTY OF ____ §
§
STATE OF TEXAS §

1. My name is Pamela H. Deveau. I am over the age of 21, I have never been convicted of a felony, and I am competent to make this affidavit.

2. I am a Benefit Consultant for Aetna U.S. Healthcare. In that capacity, I am familiar with and have access to various agreements between Aetna U.S. Healthcare of North Texas, Inc. ("Aetna") and employers that establish and maintain employee welfare benefit plans for the their employees and their eligible dependents. The statements contained in this affidavit are based on my personal knowledge and upon the business records of Aetna identified herein, and are true and correct.

3. Exhibit 1 to this affidavit is a true and correct copy of the Group Agreement between Aetna and Monitronics International Inc. ("Monitronics"). Exhibit 2 to this affidavit is a true and correct copy of the Certificate of Coverage between Aetna and Monitronics. As reflected in Exhibits 1 and 2 hereto, Monitronics established and maintains an employee benefit plan for the purpose of providing welfare benefits, including medical benefits, to its eligible employees and their dependents.

4. The medical benefits available under the plan are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 12-27.

5. The class of beneficiaries, *i.e.*, the Subscribers (employees) and their Covered Dependents, are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 8, 49, 53.

6. The claims procedures for receiving benefits and the claims appeal process are described in the Certificate of Coverage. *See* Exhibit 2 at pp. 6, 35-39.

7. The source of financing for the plan is described in the Group Agreement. *See* Exhibit 1 at pp. 2-3.

8. Exhibits 1 and 2 and the attachments thereto were kept by Aetna in the regular course of business, and it was the regular course of business of Aetna for an employee or representative of Aetna, with knowledge of the act, event, condition, opinion or diagnosis, to make the records or to transmit information thereof to be included in such records, and the records were made at or near the time or reasonably soon thereafter.

Further Affiant Sayeth Naught.

/s/
Pamela H. Deveau

SWORN TO AND SUBSCRIBED BEFORE ME this 9th day of February, 2001.

[Seal]

/s/
Notary Public in and for
the State of Texas

[Exhibit 1 To Affidavit Of Pamela H. Deveau]

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT COVER SHEET

Contract Holder:	Monitronics International Inc.
Contract Holder Number:	148028 001 TX01
HMO Benefit Level:	CITIZEN PLAN Benefits Package
Group Agreement Effective Date:	December 1, 1999
Term of Group Agreement:	The initial term shall be: From December 1, 1999 to November 30, 2000 Thereafter, subsequent terms shall be: From December 1st to November 30th

Initial HMO Premium Rates:		
	Single	**$148.23**
	Parent & Child	**$276.66**
	Parent & Children	**$276.66**
	Couple	**$334.54**
	Family	**$459.94**

Term of Rates:	From December 1, 1999 to November 30, 2000. These rates are subject to adjustments based upon final regulatory

determinations.

Premium Due Dates:	The Group Agreement Effective Date and the 1st day of each succeeding calendar month.

NOTICE: Written notice shall be given by U.S. Mail, postage prepaid, to HMO at:

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
1650 Highway 6, Suite 200
Sugar Land, TX 77478
1-877-884-5518 toll free

and to Contract Holder at:

Monitronics International Inc
Ms. Kimberly Neal
Human Resource Assoc
Monitronics International Inc
12801 Stemmons Fwy, Ste 821
Dallas TX 75234-5835

_____
(Signature Date)

HMO(s):

By: _____/s/_____
David C. Kolton

Title: Vice President
Aetna U.S. Healthcare Inc.

Contract Holder:

By:_____(Signature)
_____(Printed Name)
Title:_____

Contract Holder Number: 148028
Contract Holder Locations: 001

Contract Holder Service Areas: TX01
Contract Holder Group Agreement Effective Date:
December 1, 1999

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

GROUP AGREEMENT

This is a **Group Agreement** between Aetna U.S. Healthcare of North Texas Inc. (hereinafter referred to as "**HMO**") and Monitronics International Inc (hereinafter referred to as "**Contract Holder**").

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the terms, conditions, rights, and privileges as set forth in this **Group Agreement** and the Certificate of Coverage. **Members** covered under this **Group Agreement** are subject to all the conditions and provisions contained herein.

This **Group Agreement** is governed by applicable federal law and the laws of Texas.

If any provision of this **Group Agreement** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect. In consideration of the Premium payments made by or on behalf of the **Contract Holder**, **HMO** shall provide coverage for those services described in the Certificate of Coverage subject to the terms and conditions set forth in this **Group Agreement** and the Certificate of Coverage (herein after referred to as "**Certificate**") which is attached to this **Group Agreement**, and fully incorporated herein by reference. The terms and conditions used in this **Group Agreement** have the same meaning given those terms in the Certificate unless otherwise specifically defined in this **Group Agreement**.

Group Agreement Effective Date: December 1, 1999
Contract Holder Number: 148028

PREMIUMS

A. **Premiums** for the **Covered Benefits** under this **Group Agreement** are set forth in the Cover Sheet attached hereto, which is fully incorporated herein by reference.

B. The **Premiums** set forth in the Cover Sheet shall be effective for the initial term of this **Group Agreement**. Thereafter, if **HMO** gives a minimum of 30 days prior written notice to the **Contract Holder**, **HMO** may change the **Premiums**:

- upon the renewal date of this **Group Agreement**; or
- upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to **Members**.

Payment of the applicable **Premium** on and after that date shall constitute acceptance of those changes by the contract Holder, individually and on behalf of all **Members** enrolled under this **Group Agreement**.

C. **Premiums** are payable to **HMO** on or in advance of each **Premium** due date at the corporate offices of **HMO** unless otherwise specified by **HMO** in writing. The payment of any **Premium** shall not maintain coverage under this **Group Agreement** in force beyond the date when the next payment becomes due; however, a 31 day grace period, during which time this **Group Agreement** will remain in force, shall be granted for payment of each amount due after the first. The **Contract Holder** shall remain liable for the payment of the **Premium** for the time coverage was in effect during the grace period and the **Member** shall remain liable for **Copayments** owed. A check is not a payment until it is honored by a bank. **HMO** reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

D. Retroactive adjustments to the **Contract Holder's** billings may be made by **HMO** for the termination of **Members** not posted to previous **Contract Holder** billings. However, the **Contract Holder** may only receive a maximum of 2 month's credit for Member terminations which occurred more than 31 days prior to the date **HMO** was notified of such termination by the **Contract Holder**. Retroactive additions will be made at the discretion of **HMO** based upon eligibility guidelines, as detailed in the **Certificate** and on the Schedule of Benefits, and are subject to the payment of all applicable **Premiums**. As between **HMO** and the **Contract Holder**, the **Contract Holder** shall be responsible for any claims paid by **HMO** with respect to a **Member**, to the extent **HMO** relied on the **Contract Holder's** submitted enrollment to confirm coverage where coverage was not valid.

E. **Premiums** shall be paid in full for **Members** whose coverage is effective on the **Premium** due date or whose coverage terminates on the last day of the **Premium** period.

F. If the **Premiums** are not paid by the **Premium** due date, **HMO** will require the **Contract Holder** to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the 31st day after the **Premium** due date.

In the event of non-payment of any amount due, **HMO** shall be entitled to all remedies prodded for in law or in equity.

ENROLLMENT

Enrollment for eligible individuals, as described in the **Certificate**, will be permitted during the **Open Enrollment Period**, or within 31 days from the date the individual and any dependent becomes eligible for coverage. Completed enrollment information must be submitted to the **Contract**

Holder for transmittal to **HMO**. Eligible individuals and any eligible dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment**. Coverage shall not become effective until confirmed by **HMO**. The **Open Enrollment Period** shall be consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit representatives of **HMO** to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure.

There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the Schedule of Benefits.

The eligibility of the group, the composition of the group and the eligibility requirements used to determine membership in the group which exist at the effective date of this **Group Agreement** are material to the execution of this **Group Agreement** by **HMO**. The **Contract Holder** shall not during the term of this **Group Agreement** modify the **Open Enrollment Period**, the waiting period as described on the Schedule of Benefits, or any other eligibility requirements as described in the **Certificate** and on the Schedule of Benefits, for the purposes of enrolling the **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless agreed to in writing by **HMO**.

CONTRACT HOLDER TERMINATION

A. This **Group Agreement** may be terminated the **Contract Holder** on any **Premium** due date by giving 60 days' prior written notice.

B. The **Contract Holder** may terminate this **Group Agreement** as of its renewal date, by providing **HMO**

written notice of non-renewal not less than 60 days prior to the renewal date.

C. The **Contract Holder** may terminate this **Group Agreement** as of the date any Premium change would become effective, by providing **HMO** with written notice of termination not less than 30 days prior to such effective date.

D. **HMO** may terminate or non-renew the **Group Agreement** if:

1. **HMO** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Group Agreement** within the grace period. **HMO** may terminate this **Group Agreement** as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Group Agreement** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period;
2. the **Contract Holder** has performed an act or practice that constitutes fraud or intentional misrepresentation of a material fact in obtaining coverage under this **Group Agreement**;
3. The **Contract Holder** has failed to comply with a material plan provision relating to any employer contribution or group participation rules, under applicable state or federal law;
4. **HMO** ceases to offer coverage in the market in accordance with state law;
5. **HMO** ceases to offer coverage of a specific product in the market in accordance with state law;

6. the **Contract Holder** no longer has any enrollee under the plan who lives, resides, or works in the **Service Area**;

7. the **Contract Holder's** membership in the association, through which coverage is obtained, ceases.

E. Upon thirty days written notice to the **HMO**, the **Contract Holder** may terminate this **Group Agreement** in the case of a material change by the **HMO** to any provisions required to be disclosed to the **Contract Holder** or **Members** pursuant to State law.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Group Agreement**.

No change in the eligibility or participation requirements of the **Contract Holder** shall be permitted to affect eligibility or enrollment under this **Group Agreement** unless such change is agreed to by **HMO** and the **Contract Holder**, and is not otherwise contrary to applicable state or federal laws, rules or regulations. Breach of this provision is considered a material breach of this **Group Agreement** and may be the basis for termination by giving 60 days' prior written notice. It is the responsibility of the **Contract Holder** to notify the Subscribers of the termination of the **Group Agreement** in compliance with all applicable laws. However, **HMO** reserves the right to notify **Subscribers** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

In accordance with the **Certificate**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

INDEPENDENT CONTRACTOR RELATIONSHIPS

A. Between **Participating Providers** and **HMO**.

The relationship between **HMO** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **HMO** nor is **HMO** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **HMO** makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**.

B. Between the **Contract Holder** and **HMO**.

The relationship between **HMO** and the **Contract Holder** is limited to a contractual relationship between independent contractors. Neither party is an agent nor employee of the other in performing its obligations pursuant to this **Group Agreement**.

ADMINISTRATION OF THE AGREEMENT

HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Group Agreement**.

A. Entire Agreement.

This **Group Agreement**, including the Group Application, Cover Sheet, Certificate of Coverage, Schedule of Benefits, any Riders, and any amendments, endorsements, inserts or attachments, constitutes the entire **Group Agreement** between the **Contract Holder** and

HMO, and on the **Effective Date of Coverage**, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations, and discussions between the parties, whether written or oral, previously issued by **HMO** for **Covered Benefits** provided by this **Group Agreement**.

All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **HMO** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

B. Amendments.

This **Group Agreement** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **HMO**, and this **Group Agreement** shall be deemed to be amended to conform therewith at all times. This **Group Agreement** may be changed at any time for any other reason by agreement between **HMO** and the **Contract Holder**, without the consent of any employee, **Member**, or other person. Except as detailed below, any amendments to this **Group Agreement** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **HMO**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **HMO** by making any other commitment or representation or by giving or receiving any information. No change in this **Group Agreement** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **HMO**.

Formal acceptance of an amendment to this **Group Agreement** by the **Contract Holder** shall not be required if:

1. the change was requested by either the **Contract Holder** or **HMO** and is agreed to in writing by the other; or
2. the change is required to bring the **Group Agreement** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Group Agreement** is delivered; or
3. the **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

C. Forms.

HMO shall supply the **Contract Holder** with a reasonable supply of its forms and descriptive literature. The **Contract Holder** shall distribute **HMO's** forms and descriptive literature to any eligible individual who becomes eligible for coverage. The **Contract Holder** shall, within 20 business days of receipt from an eligible individual, forward all applicable forms and other required information to **HMO**.

D. Records.

HMO shall maintain **Member** records. The records will contain key facts about the **Member's** coverage. Each month during the period of this **Group Agreement**, on forms approved by **HMO**, the **Contract Holder** shall furnish to **HMO** such information as may reasonably be required to administer the **Group Agreement**. This includes, but is not limited to, information needed to enroll **Members** of the **Contract Holder**, process terminations, and effect changes in

family status and transfer of employment of **Members**. **HMO** shall not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **HMO**.

The **Contract Holder** shall make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **HMO** for inspection, at **HMO's** expense, at the **Contract Holder's** office, during regular business hours, upon reasonable advance request from **HMO**. This provision shall survive the termination of this **Group Agreement** as necessary to resolve outstanding financial or administrative issues pursuant to this **Group Agreement**.

E. Clerical Errors.

Incorrect information furnished to **HMO** may be corrected, provided that **HMO** has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if **HMO**, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to **Members**. Upon discovery of such errors or delay, an adjustment of **Premiums** shall be made. In no case will adjustments in coverage or **Premiums** be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested addition, deletion, or change in coverage.

F. Claim Determinations.

HMO has complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **HMO** shall have discretionary authority to determine whether and to what ex-

tent eligible individuals and beneficiaries are entitled to coverage and construe any disputed or doubtful terms under this **Group Agreement**. **HMO** shall be deemed to have properly exercised such authority unless **HMO** abuses its discretion by acting arbitrarily and capriciously.

G. Fraudulent or Intentional Misrepresentations.

If any relevant fact as to a **Member** is found to have been misrepresentation, an equitable adjustment of **Premiums** may be made. If the misrepresentation affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force.

H. Incontestability.

Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

1. No statement made by the **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
2. No statement made by the **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for 2 years from its effective date.
3. No statement made by a **Member** shall be used in defense of a claim for loss incurred or commencing after coverage has been in effect for 2 years.

I. Assignability.

No rights or benefits under this **Group Agreement** are assignable by the **Contract Holder** to any other party unless approved by **HMO**.

J. Waiver.

HMO's failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **Certificate** incorporated hereunder, at any given time or times, shall not constitute a waiver of **HMO's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

K. Notices.

Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or Cover Sheet, or to any more recent address of which the sending party has received written notice.

L. Third Parties.

This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

M. Non-Discrimination.

The **Contract Holder** agrees to offer participation in **HMO** to all persons as described in the Subscriber Eligibility section of the Schedule of Benefits under terms and conditions no less favorable than those for any alternate health benefit plans. The **Contract Holder** agrees to make no attempt, whether through differential **Contract Holder Premium** contributions or otherwise to encourage or discourage enrollment in **HMO** of eligible

individuals and eligible **Dependents** based on health status or health risk.

N. Execution of this Agreement.

This **Group Agreement** shall be executed by **HMO** and the **Contract Holder** once the Group Application, which is attached hereto and fully incorporated herein by reference, is completed and signed. However, payment of the applicable Premium on and after the effective date of this **Group Agreement** shall constitute execution of this **Group Agreement** by the **Contract Holder**.

O. Inability to Arrange Services.

In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **HMO's Participating Providers** or entities with whom **HMO** has arranged for services under this **Group Agreement**, or similar causes, the rendition of medical or **Hospital** benefits or other services provided under this **Group Agreement** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

P. Use of the HMO Name and all Symbols, Trademarks, and Service Marks.

HMO reserves the right to control the use of its name and all symbols, trademarks, and service marks presently existing or hereinafter established with respect to it. The **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or

promotional materials or otherwise without prior written consent of **HMO** and will cease any and all usage immediately upon request of HMO or upon termination of this **Group Agreement**.

Q. Worker's Compensation.

The **Contract Holder** is responsible for protecting **HMO's** interests in any workers compensation claims or settlements with any eligible individual. **HMO** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

At the signing of this **Group Agreement** and upon renewal, the **Contract Holder** shall submit proof of their worker's compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Worker's Compensation. The **Contract Holder** is also required to submit a monthly report to **HMO** listing all worker's compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individual.

R. Conflict Between **Group Agreement** and **Certificate**

Any direct conflict between the **Group Agreement** and the **Certificate** will be resolved according to the terms which are most favorable to the **Subscriber**.

[Exhibit 2 To Affidavit Of Pamela H. Deveau]

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)
2777 Stemmons Freeway, Suite 400
Dallas, Texas 75207
214-200-8000 or 1-800-992-7947

CERTIFICATE OF COVERAGE

This Certificate of Coverage ("**Certificate**") is part of the Group Agreement ("**Group Agreement**") between Aetna U.S. Healthcare of North Texas Inc., hereinafter referred to as HMO, and the Contract Holder. The **Group Agreement** determines the terms and conditions of coverage. Provisions of this **Certificate** include the Schedule of Benefits, and any amendments, riders or endorsements. Amendments, riders or endorsements may be delivered with the **Certificate** or added thereafter.

HMO agrees with the **Contract Holder** to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this **Certificate**. **Members** covered under this **Certificate** are subject to all the conditions and provisions of the **Group Agreement**.

This **Certificate** describes covered health care benefits. Coverage for services or supplies is provided only if it is furnished while an individual is a **Member**. This means that coverage is provided only for health care services furnished while this coverage is in force. Except as shown in the Continuation and Conversion section of this **Certificate**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings when used in this **Certificate**. The defined terms appear in bold type with initial

capital letters. The definitions of those terms are found in the Definitions section of this **Certificate**.

The Group Agreement under which this Certificate is issued is not a policy of workers' compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers' compensation system. This Certificate is governed by applicable federal law and the laws of Texas.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS CERTIFICATE IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE 31 DAY GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THE GROUP AGREEMENT AND THE CERTIFICATE OF COVERAGE CONTAIN NO ARBITRATION PROVISION.

THIS CERTIFICATE APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CERTIFICATE.

NO PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY OR AGENCY IS AN AGENT OR EMPLOYEE OF HMO.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact HMO's Member Service Department at 1-800-992-7947.

You may call HMO's toll-free telephone number for information or to make a complaint at 1-800-992-7947

You may also write to HMO at:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact HMO first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener information o para someter una queja:

Puede comunicarse con su HMO Member Service Department al 1-800-992-7947.

Usted puede llamar al numero de telefono gratis de (company)'s para information o para someter una queja al 1-800-992-7947

Usted tambien puede escribir a HMO:

Aetna U.S. Healthcare of North Texas Inc.
P.O. Box 569441
Dallas, TX 75356-9441

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTES SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el HMO primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER:

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-228-1570.

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS:

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-228-1570.

Su queja sera referida a la agencia estatal que regula el hospital o centro de tratamiento para la dependencia quimica.

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HMO PROCEDURE

A. **Selecting a Participating Primary Care Physician.**

At the time of enrollment, each **Member** should select a **Participating Primary Care Physician (PCP)** from **HMO's** Directory of **Participating Providers** to access Covered Benefits as described in this **Certificate**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf if a **Member** does not select a **PCP** at the time of enrollment, the **HMO** will assign a **PCP** to the **Member**. The **Member** retains the right to reject the **PCP** assigned the **Member** however the **Member** must select another **PCP** at the time of rejection. The **HMO** will, in good faith, assign a **PCP** located near to a **Member's** residence or place of employment.

A **Member** who has been diagnosed with a chronic, disabling or life threatening illness may apply to the **HMO's** Medical Director to be able to select a **Participating Specialist** as the **Member's PCP**. The **HMO** will specify to the **Member** the information necessary, including certification of the medical need, and signatures of the **Member** and the **Participating Specialist** interested in serving as the **Member's PCP**. The **Participating Specialist** must meet the **HMO's** requirements for **PCP** participation and be willing to accept the coordination of all the **Member's** healthcare needs. The designation of the **Participating Specialist** as the **Member's PCP** will not be retroactive. If the request for special consideration of a **Participating Specialist** is denied, a **Member** may appeal the decision through the **HMO's** established Grievance/Complaint Procedure.

B. **The Primary Care Physician**.

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to a **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Certificate**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the **Covered Benefits** section of this **Certificate**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

Should **Medically Necessary** covered services be unavailable through a **Participating Provider**, upon the request of the **Primary Care Physician** or **Participating Provider** and with prior approval of the **HMO**, a **Referral** may be made to a non-**Participating Provider** for those **Medically Necessary** covered services.

The **HMO** will allow for a review by a **Specialist** of the same or similar specialty as the type of **Physician** or **Provider** to whom the **Referral** was requested prior to the **HMO's** approval of the **Referral**.

C. **Availability of Providers**.

HMO cannot guarantee the availability or continued participation of a particular **Provider**. Either **HMO** or any **Participating Provider** may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection. The **Member** must then cooperate with **HMO** to select another **PCP**.

D. **Changing a PCP**.

A **Member** may change the **PCP** at any time by calling the **Member** Services 800 telephone number listed on the **Member's** identification card or by written or electronic submission of the **HMO's** change form. A **Member** may contact **HMO** to request a change form or for assistance in completing that form. The change will become effective upon **HMO's** receipt and approval of the request. The **Member** may change their **PCP** up to four times in a twelve month period.

E. **Ongoing Reviews.**

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Certificate**. If **HMO** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **HMO** to seek a review of the determination.

F. **Provider Communication.**

HMO will not prohibit, attempt to prohibit or discourage any **Health Professional** from discussing or communicating to a **Member** or a **Member's** designee any information or opinions regarding the **Member's** health care, any provisions of health care plan as it relates to the medical needs of the **Member** or the fact

that the **Health Professional's** contract with the **HMO** has terminated or will no longer be providing services under the **HMO**.

ELIGIBILITY AND ENROLLMENT

A. **Eligibility.**

1. To be eligible to enroll as a **Subscriber**, an individual must:

   a. meet all applicable eligibility requirements agreed upon by the **Contract Holder** and **HMO**; and

   b. live or work in the **Service Area**.

2. To be eligible to enroll as a **Covered Dependent**, the **Contract Holder** must provide dependent coverage for **Subscribers**, and the dependent must be:

   a. the spouse of a **Subscriber** under this **Certificate**; or

   b. a dependent unmarried child (including natural, foster, step, legally adopted children, proposed adoptive children, a child under court order, and dependents of dependents) who meets the eligibility requirements described on the Schedule of Benefits.

B. **Enrollment.**

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in **HMO** regardless of health status, age, or requirements for health services. Submission of complete enrollment information and **Premium** payment to **HMO** must be made within 31 days from the eligibility date.

1. **Newly Eligible Individuals and Eligible Dependents.**

An eligible individual and any eligible dependents who are eligible may enroll.

2. **Open Enrollment Period**

Eligible individuals or any dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent **Open Enrollment Period** upon submission of complete enrollment information and **Premium** payment to **HMO**.

3. **Enrollment of Newly Eligible Dependents.**

   a. **Newborn Children.**

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, notification of the birth and any required additional **Premium** must be received by **HMO** not later than the 31st day after the date of birth. If coverage does not require the payment of an additional **Premium** for a **Covered Dependent**, the **Subscriber** must still enroll the child within 31 days after the date of birth.

The coverage for newly born; adopted children and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this **Certificate**. Coverage includes necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

b. Adopted Children.

A legally adopted child, a child for whom a **Subscriber** is a court appointed legal guardian, or a child for which the **Subscriber** is a party in a suit in which the adoption of the child by the **Subscriber** is sought, and who meets the definition of a **Covered Dependent**, will be treated as a dependent. The **Subscriber** must make a written request for coverage within 31 days of the date the adoption is final or the legal guardianship has been decreed, or within 31 days after the **Subscriber** is a party in a suit for adoption.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

4. Special Rules Which Apply to Children.

a. Qualified Medical Support Order.

Coverage is available for a dependent child not residing with a **Subscriber** and who resides outside the **Service Area**, if there is a qualified medical child support order requiring the **Subscriber** to provide dependent health coverage for a non-resident child, and is issued on or after the date the **Subscriber's** coverage becomes effective. The coverage shall be comparable to the coverage provided to other **Covered Dependents**. The child must meet the definition of a **Covered Dependent**, and the **Subscriber**

must make a written request for coverage within 31 days of the court order.

The initial coverage will not be affected by any provision in this **Certificate** which:

i. requires evidence of good health acceptable to **HMO** for coverage to become effective;
ii. delays coverage due to a confinement; or
iii. limits coverage as to a preexisting condition.

b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the **Subscriber** for support and maintenance, and who is incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent lost eligibility as defined on the Schedule of Benefits; Dependent Eligibility In order to continue coverage for a handicapped child, the **Subscriber** must provide proof of the child's incapacity and dependency to **HMO** within 31 days of the date the child attains the limiting age. Subsequent proof may be requested by the **HMO**, not more frequently than annually, and must be provided by the **Subscriber** in order to continue such coverage. This eligibility provision will no longer apply on the date the dependent's incapacity ends.

5. Notification of Change in Status.

It shall be a **Member's** responsibility to notify **HMO** of any changes which affect the **Member's** coverage under this **Certificate**. Such status changes include, but are not limited to, change of address, change of **Covered Dependent** status, and

enrollment in Medicare or any other group health plan of any **Member**. Additionally, if requested, a **Subscriber** must provide to **HMO**, within 31 days of the date of the request, evidence satisfactory to **HMO** that a dependent meets the eligibility requirements described in this **Certificate**.

An eligible individual and any eligible dependents may be enrolled if the eligible individual's spouse was covered under another health benefit plan and lost coverage because of termination of coverage, for reasons other than gross misconduct, within 31 days of the loss of coverage even though it is not during the **Open Enrollment Period**. The eligible individual or the eligible dependent will not be subject to the late enrollment provision described below. **HMO's** completed change form must be submitted to the **Contract Holder** within 31 days of the event causing the change in status.

An eligible individual and any eligible dependents may be enrolled during a special enrollment period. A special enrollment period occurs when:

a. an eligible individual or an eligible dependent's covered under another group health plan or self-funded employer health benefit plan when initially eligible for coverage under **HMO**;

b. the eligible individual or eligible dependent declines coverage in writing under **HMO** during the initial eligibility stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or

self-funded employer health benefit plan for one of the following reasons:

i. termination of employment; or
ii. reduction in the number of hours of employment; or
iii. termination of contributions toward the premium made by the employer, or
iv. death of a spouse or divorce; or

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of the **HMO Certificate**; and

d. the eligible individual or eligible dependent enrolls within 31 days of the loss.

The effective date of coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to any late enrollment or pre-existing condition provision described in this **Certificate**.

C. **Effective Date of Coverage.**

Coverage shall take effect at 12:01 a.m. on the **Member's** effective date. Coverage shall continue in effect from month to month subject to payment of **Premiums** made by the **Contract Holder** and subject to the Contract Holder Termination section of the **Group Agreement**.

Hospital Confinement on Effective Date of Coverage.

If a **Member** is an inpatient in a **Hospital** on the **Effective Date of Coverage**, the **Member** will be covered as of that date. Such services are not covered if the **Member** is covered by another health plan on that date and the other health plan is responsible for the cost of the services. **HMO** will not cover any service that is not a **Covered Benefit** under this **Certificate**. To be covered, the **Member** must utilize **Participating Providers** and is subject to all the terms and conditions of this **Certificate**.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Certificate**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **Certificate** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely

to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient Hospital Services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO's** Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member's** health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO's** attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.

If a **Member** has questions regarding coverage under this **Certificate**, the **Member** may call the Member services 800 telephone number listed on the **Member's** identification card

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY AS DESCRIBED IN THIS CERTIFICATE, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

A. **Primary Care Physician Benefits.**

1. Office visits during office hours.
2. After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:
    a. call the **PCP's** office; and
    b. identify himself or herself as a **Member;** and
    c. follow the **PCP's** or covering **Physician's** instructions.

    If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care Benefits section of this **Certificate**.
3. Hospital visits.
4. Periodic health evaluations to include:
    a. well child care from birth including immunizations and booster doses of all immunizing

agents used in child immunizations, including but not limited to immunization against diphtheria; haemophilus; influenza type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella, which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services or as required by law.

b. routine physical examinations.

c. routine gynecological examinations, including pap smears, for routine care, administered by the **PCP**. Or the **Member** may also go directly to a **Participating** gynecologist without a **Referral** for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this **Certificate** for a description of these benefits.

d. routine speech and hearing screenings.

e. immunizations (but not if solely for the purpose of travel or employment).

f. routine vision screenings.

5. Injections, including allergy desensitization injections.
6. Casts and dressings.
7. Health Education Counseling and Information.

B. **Diagnostic Services.**

Services include, but are not limited to, the following:

1. diagnostic, laboratory, and x-ray services.
2. mammograms, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from her **PCP** or gy-

necologist, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

Screening mammogram benefits for female **Members** are provided as follows:

- age 35 and older, one routine mammography every year; or
- when **Medically Necessary**.

3. prostate cancer screening, by a **Participating Provider**. The **Member** is required to obtain a **Referral** from his **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit

Prostate Cancer Screening benefits for male **Members** are provided as follows:

- age 40-49, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year, if the **Member** is at an increased risk of developing prostate cancer as determined by his physician; or
- age 50 and older, one screening which will include a prostate specific antigen (PSA) blood test and a digital rectal examination every year.

C. **Specialist Physician Benefits.**

Covered Benefits include outpatient and inpatient services.

D. **Direct Access Specialist Benefits.**

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.

- Open Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems. Open access includes care related to pregnancy; care for-all active gynecological conditions; and diagnosis, treatment and referral for any disease or condition which is within the scope of the professional OB/GYN practice. See the Infertility Services section of this **Certificate** for a description of **Infertility** benefits.
- Routine Eye Examinations, including refraction, as follows:
  1. if **Member** is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
  2. if **Member** is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
  3. if **Member** is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
  4. if **Member** is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

E. **Maternity Care and Related Newborn Care.**

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers** are a **Covered Benefit**. To be covered for these benefits, the **Member** must choose a **Participating** obstetrician from **HMO's** list of **Participating Providers**.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area**

unless the **Member** receives prior authorization from **HMO**. As with any other medical condition, **Emergency Services** are covered when **Medically Necessary**.

F. **Inpatient Hospital & Skilled Nursing Facility Benefits.**

A **Member** is covered for services only at participating **Hospitals** and **Participating Skilled Nursing Facilities**. All services are subject to preauthorization by **HMO**. In the event that the **Member** elects to remain in the **Hospital** or **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **HMO** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** or **Skilled Nursing Facility** for such additional **Hospital**, **Skilled Nursing Facility**, **Physician** and other **Provider** services, and **HMO** shall not be financially responsible for such additional services.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is prodded for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;
2. a minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or
3. a shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for timely post-delivery care. Post-delivery care may be provided to the mother and child by a **Physician**, registered nurse, or other appropriate licensed health care **Provider** and

may be provided at the mother's home, a health care **Provider's** office, or a health care facility. Benefits include postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments, including parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care. A **Copayment** will not apply for home health care visits.

As an exception to the **Medically Necessary** requirements of this **Certificate**, the following coverage is provided for a **Member** following a mastectomy:

1. a minimum of 48 hours of inpatient care in a **Participating Hospital** following a mastectomy;
2. a minimum of 24 hours of inpatient care in a **Participating Hospital** following a lymph node dissection for the treatment of breast cancer.

A **Member** may request a shorter length of stay if the **Member's Participating Provider** determines the shorter stay to be appropriate.

Coverage for **Skilled Nursing Facility** benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. **Transplants.**

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these proce-

dures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.

H. **Outpatient Surgery Benefits.**

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to preauthorization by **HMO**.

I. **Chemical Dependency Benefits.**

A **Member** is covered for the following services as authorized and provided by **Participating Behavioral Health Providers**.

1. Outpatient care benefits are covered for **Detoxification** and treatment of **Chemical Dependency**. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the **Member's PCP** for the abuse of or addiction to alcohol or a controlled substance.

2. Inpatient care benefits in a **Participating Hospital** or treatment facility that is a **Participating Provider** are covered for the medical complications and treatment of **Chemical Dependency** and **Detoxification**. Benefits include medical treatment and referral services for **Chemical Dependency** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **Physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray, psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

J. **Mental Health Benefits.**

A **Member** is covered for services for the treatment of the following **Mental or Behavioral Conditions** through **Participating Behavioral Health Providers**.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

2. Benefits for **Serious Mental Illness**

Inpatient care received in a participating **Hospital** or **Participating Mental Health Treatment Facility** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** while the **Member** is a full-time inpatient is covered. Coverage is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Outpatient care received from a **Participating Provider** for the necessary care, diagnosis and treatment of a **Serious Mental Illness** is covered. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits. Any outpatient visits for the purpose of medication management will not be counted toward the maximum number of visits, and visits for medication management will be under the same terms and conditions as for outpatient visits for treatment of physical illness generally.

Coverage for **Serious Mental Illness** will include the same **Copayments** as for any other physical illness.

K. **Emergency Care Benefits.**

1. A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**.

Benefits include:

a. a medical screening examination/evaluation, in accordance with any State or Federal law, the purpose of which is to determine whether an emergency medical condition exists;

b. the treatment and stabilization of the **Member** for the emergency medical condition;

c. services originating in a **Hospital** emergency facility or comparable facility following treatment or stabilization of an emergency medical condition, as approved by **HMO**. In addition, the **HMO** reserves the right to approved or deny coverage of any post-stabilization care as requested by a **Provider**, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the **Member**, but in no case to exceed one hour from the time of the request

The **Copayment** for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-**Participating Provider** located either within or outside the **HMO Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **HMO** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is **Medically Necessary**, the **Member** will be reimbursed for the cost as determined by **HMO**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

Medical transportation is covered during a **Medical Emergency**.

2. A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a **Member** after the **Medical Emergency** care has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

L. **Rehabilitation Benefits.**

A **Member** is covered for rehabilitation, services, and therapies benefits that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

M. **Home Health Benefits.**

The following services are covered when rendered by a **Participating** home health care agency. Preauthorization must be obtained from the **Member's** attending

Participating Physician. **HMO** shall not be required to provide home health benefits when **HMO** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. Skilled nursing services for a **Homebound Member**. Treatment must be provided by or supervised by a registered nurse.
2. Services of a home health aide. These services are covered only when the purpose of the treatment is **Skilled Care**.
3. Medical social services. Treatment must be provided by or supervised by a qualified medical **Physician** or social worker, along with other **Home Health Services**. The **PCP** must certify that such services are necessary for the treatment of the **Member's** medical condition.
4. Physical, speech and hearing, or occupational therapy is covered.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill **Member** are covered when preauthorized by **HMO**. Services may include home and **Hospital** visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family **Member**; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling. Homemaker or caretaker services, and any service not solely related to the care of the **Member**, including but not limited to, sitter or companion services for the **Member** or other **Members** of the family, transportation, house cleaning, and maintenance of the house

are not covered. Coverage is not provided for **Respite Care**.

O. **Prosthetic Appliances.**

The **Member's** initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease or injury or congenital defects are covered, when such devices are prescribed by a **Participating Provider** and authorized in advance by **HMO**. Coverage includes repair and replacement when due to congenital growth Instruction and appropriate services required for the **Member** to properly use the item (such as attachment or insertion) are covered.

P. **Injectable Medications.**

Injectable medications, including those medications intended to be self administered, are a **Covered Benefit** when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section of this **Certificate**. Medications must be prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines, and approved in advance of treatment by **HMO**. If the drug therapy treatment is approved for self-administration, the **Member** is required to obtain covered medications at an

HMO Participating pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. **Infertility Services.**

Infertility services are covered upon prior authorization by **HMO** when provided by a **Participating Provider**. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of **Infertility** which are furnished to a **Member**.

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ.

S. **Diabetes Related Benefits.**

Benefits for the treatment of diabetes and associated conditions. Coverage includes diabetes equipment, diabetes supplies and diabetes self-management training. All provisions applicable to other illness and surgical treatment, including **Copayments**, will apply to benefits for diabetes related coverage.

T. **Additional Benefits.**

Durable Medical Equipment Benefits. Durable Medical Equipment will be provided when preauthorized by **HMO**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **HMO** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Certificate**. **HMO** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **HMO**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon preauthorization by **HMO**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **HMO** that:

1. it is needed due to a change in the **Member's** physical condition; or
2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

A **Copayment**, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this

service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

A. **Exclusions.**

The following are not **Covered Benefits** except as described in the Covered Benefits section of this **Certificate** or by a rider attached to this **Certificate**:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by **HMO**.
- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary** Services. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical

Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy.

- Court ordered services, or those required by court order as a condition of parole or probation.
- **Custodial Care**.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibulopiasty treatment of periodontal disease, and dental implants are not covered. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts. Dental services and supplies for treatment of temporomandibular joint (TMJ) dysfunction except for diagnostic and medical/surgical treatment of TMJ.
- **Durable Medical Equipment**, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.
- Educational services and treatment of behavioral disorders, together with services for remedial education in-

cluding evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- **Experimental** or **Investigational Procedure**, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or Investigational health care procedures or pharmacological regimes as determined by **HMO**, unless approved by **HMO** prior to the treatment being rendered

  This exclusion will not apply with respect to drugs:

  1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  3. **HMO** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

- False teeth.
- Hair analysis.
- Health services, specifically charges for health services, incurred before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Certificate**. This does not include covered services

resulting from complications of pregnancy incurred after the **Member's** effective date.

- Hearing aids.
- Household equipment, including but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds.
- Household fixtures, including but not limited to, the purchase or rental of escalators, elevators, and swimming pools.
- Hypnotherapy, except when specifically approved by **HMO**.
- Implantable drugs.
- **Infertility** services, including the treatment of male and female **Infertility**, injectable **Infertility** drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg program or gestational carriers. This exclusion does not apply to artificial insemination, **Medically Necessary** services to diagnose and treat the underlying medical cause of **Infertility**, or donor sperm.
- Inpatient care for **Serious Mental Illness** which is not provided in a **Hospital** or **Mental Health Treatment Facility**; non-medical ancillary services and long-term rehabilitation services for **Serious Mental Illness**.
- Inpatient treatment for **Mental or Behavioral Conditions** unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive

treatment at government facilities and which facilities are reasonably available to the **Member**.

- Non-medically necessary services, including but not limited to, those services and supplies:

  1. which are not **Medically Necessary**, as determined by **HMO**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  2. that do not require the technical skills of a medical, mental health or a dental professional;
  3. furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  4. furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient prescription or non-prescription drugs and medicines unless this benefit is covered by a Rider attached to this Certificate of Coverage.
- Outpatient supplies, including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and re-

agent strips, except that this exclusion does not apply to diabetes supplies.

- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.
- Private duty or special nursing care, unless preauthorized by **HMO**.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship, counseling, and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails, calluses and corns.
- Services for which a **Member** is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be trade.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a **Covered Benefit** under this **Certificate**, even when a prior **Referral** has been issued by a **PCP**.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific injectable drugs, including:
  1. experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  2. needles, syringes and other injectable aids, except that this exclusion does not apply to diabetes supplies;
  3. drugs related to the treatment of non-covered services; and
  4. drugs related to the treatment of **Infertility**, contraception, and performance enhancing steroids.

- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Surgical operations, procedures or treatment of obesity, except when specifically approved by **HMO**.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member's** physical characteristics from the **Member's** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded **Members** in accordance with the benefits provided in the covered Benefits section of this **Certificate**.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to **HMO** that the **Member** is covered under a workers' compensation law or similar law, but is not covered for a particular disease or injury under such law. that disease or injury will be considered "non-occupational" regardless of cause.

- Treatment of spinal disorder services, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Unauthorized services, including any service obtained by or on behalf of a **Member** without prior **Referral** issued by the **Member's PCP** or certified by **HMO**. This exclusion does not apply in a **Medical Emergency** or when it is a direct access benefit.
- Vision care services and supplies.
- Weight reduction programs, or dietary supplements.
- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.
- Services related to the care, filling, removal or replacement of impacted teeth.

B. **Limitations.**

In the event there are two or more alternative Medical Services which in the sole judgment of **HMO** are equivalent in quality of care, **HMO** reserves the right to provide coverage only for the least costly Medical Service, as determined by **HMO**, provided that **HMO** approves coverage for the Medical Service or treatment in advance.

Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Certificate** are at the sole discretion of **HMO**, subject to the terms of this **Certificate**.

DETERMINATIONS REGARDING DENIAL OF BENEFITS DUE TO INAPPROPRIATE USE OF THE HMO NETWORK ARE AT THE SOLE DISCRETION OF THE HMO.

CONTINUATION AND CONVERSION

A. **COBRA Continuation Coverage.**

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. This Act permits **Members** or **Covered Dependents** to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA, however may be eligible for continuation of coverage as provided by subsection B of this section. Continuation of Coverage—State of Texas.

1. Minimum Size of Group:

   The **Contract Holder** must have normally employed more than 20 employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   Member may elect to continue coverage for 18 months after eligibility for coverage under this **Certificate** would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or

b. **Subscriber's** death, or

c. **Subscriber's** entitlement to Medicare benefits, or,

d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this **Certificate**:

The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this **Certificate** would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

a. the last day of the 18-month period.

b. the last day of the 36-month period.

c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

d. the first day on which the **Contract Holder** ceases to maintain any group health plan.

e. the first day on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

f. the date the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs

during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.

b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to **Members** who are disabled at any time during the first 60 days of continuation coverage under this subsection (A) and only when the qualifying event is the **Member's** reduction in hours or termination. The **Member** may be charged a higher rate for the extended period.

6 Responsibility to provide **Member** with notice of Continuation Rights:

The **Contract Holder** is responsible for providing the necessary notification to **Members**, within the defined time period (sixty (60) days), as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

7. Responsibility to pay **Premiums** to **HMO**:

Coverage for the sixty (60) day period as described above to initially enroll, will be extended only where the **Subscriber** or **Member** pays the applicable **Premium** charges due within forty-five (45) days of submitting the application to the **Contract Holder** and **Contract Holder** in turn remitting same to **HMO**.

8. **Premiums** due **HMO** for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the **Group Agreement** and shall be calculated in accordance with applicable federal law and regulations.

B. **Continuation of Coverage—State of Texas.**

1. Continuation Privilege for Certain Dependents.

A **Covered Dependent** who has been a **Member** of the **HMO** for at least one year or who is an infant under one year of age may be eligible to continue coverage under this **Certificate** if coverage would otherwise terminate because of:

a. the death of the **Subscriber**,

b. the retirement of the **Subscriber**, or

c. divorce or legal separation.

A **Member** must give written notice to **Contract Holder** within 15 days of the occurrence of any of the above to activate this continuation of coverage option. Upon receiving this written notice, **Contract Holder** will send the **Member** the forms that should be used to enroll for this continuation of coverage. If the **Member** does not submit this completed enrollment form to **Contract Holder** within 60 days of the occurrence of any of the above, the **Member** will lose the right to this continuation of coverage under this section. Coverage remains in effect during this 60 day period, provided any applicable **Premiums** and administrative charges are paid

Continuation of coverage under this section will terminate on the earliest to occur of:

a. the end of the 3 year period after the date of the **Subscriber's** death or retirement;

b. the end of the 3 year period after the date of the divorce or legal separation;

c. the date the **Member** becomes eligible for similar coverage under any substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

d. the end of the period for which the **Member** has paid any applicable **Premiums**.

2. Group Continuation Privilege.

In the event a **Member's** coverage has been terminated for any reason except involuntary termination for cause, including discontinuance of the **Group Agreement** in its entirety or with respect to an insured class, and who has been continuously insured under the **Certificate** or under any group policy providing similar benefits which it replaces for at least 3 consecutive months immediately prior to the termination shall be entitled to a group continuation of coverage.

A **Member** must request, in writing, continuation of group coverage within 31 days following the later of the date the group coverage would otherwise terminate or the date the **Member** is given notice by the **Contract Holder**. The **Member's** written election of continuation, together with the first contribution required to establish **Premiums** on a monthly basis in advance, must be given to the **Contract Holder** within 31 days of the date coverage would otherwise terminate or the date the **Member** is given notice of the right of continuation by the **Contract Holder**.

Continuation of coverage under this section will terminate on the earliest to occur of:

a. six months after the date the election is made;

b. the date on which failure to make timely payments would terminate coverage;

c. the date on which the group coverage terminates in its entirety;

d. the date on which the **Member** is or could be covered under Medicare;

e. the date on which the **Member** is covered for similar benefits by another **Hospital**, surgical, medical, or major medical expense insurance policy or **Hospital** or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program;

f. the date the **Member** is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

g. similar benefits are provided or available to the **Member**, pursuant to or in accordance with the requirements of any state or federal law.

C. Conversion Privilege.

This subsection does not continue coverage under the **Group Agreement**. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by **HMO**. The conversion privilege set forth in this subsection must be initiated by the eligible **Member**. The **Contract Holder** is responsible for giving notice of the conversion privilege in accor-

dance with its normal procedures; however, in the event continuation coverage ceases pursuant to expiration of COBRA or state law, benefits as described in the COBRA Continuation Coverage or Continuation of Coverage—State of Texas sections of this **Certificate**, the **Contract Holder** shall notify the **Member** at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a **Member** ceases to be eligible for coverage under this **Certificate** and has been continuously enrolled for 3 months under **HMO**, such person may, within 31 days after termination of coverage under this **Certificate**, convert to individual coverage with **HMO**, effective as of the date of such termination, without evidence of good health provided that **Member's** coverage under this **Certificate** terminated for one of the following reasons:

a. Coverage under this **Certificate** was terminated, and was not replaced with continuous and similar coverage by the **Contract Holder;** or

b. The **Subscriber** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate**, in which case the **Subscriber** and **Subscriber's** dependents who are **Members** pursuant to this **Certificate**, if any, are eligible to convert; or

c. A **Covered Dependent** ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this **Certificate** because of the **Member's** age; or

d. Continuation coverage ceased under the COBRA Continuation Coverage section of this **Certificate**.

Any **Member** who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as **HMO** may have in effect at the time of **Member's** application for conversion, without punishing evidence of good health. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the **Group Agreement**. Upon request, **HMO** or the **Contract Holder** will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the **Subscriber** and a **Covered Dependent** child has the right to convert upon reaching the age limit or upon death of the **Subscriber** (subject to the ability of minors to be bound by contract).

D. Extension of Benefits While Member is Receiving Inpatient Care.

Any **Member** who is receiving inpatient care in a **Hospital** or **Skilled Nursing Facility** on the date coverage under this **Certificate** terminates is covered in accordance with the **Certificate** only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay; or

2. determination by the **HMO** Medical Director in consultation with the attending **Physician**, that care in the **Hospital** or **Skilled Nursing Facility** is no longer **Medically Necessary**; or
3. the date the contractual benefit limit has been reached; or
4. the date the **Member** becomes covered for similar coverage from another health benefits plan; or
5. 12 months from the termination date of the **Group Agreement**.

The extension of benefits shall not extend the time periods during which a **Member** may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of **Premium** for such coverage.

GRIEVANCE/COMPLAINT PROCEDURE

In situations when **Members** are dissatisfied with **HMO** services, the following procedures govern complaints, grievances, and grievance/complaint appeals made or submitted by **Members**. These complaints, grievances and grievance/ complaint appeals will be handled in a timely manner.

A. **Definitions.**

1. An "inquiry" is a **Member's** request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided. **HMO** encourages **Members** to resolve an individual inquiry without the initiation of a Grievance/Complaint Review.

2. A "grievance/complaint" is any dissatisfaction expressed by a **Member** orally or in writing to **HMO** with any aspect of **HMO's** operation, including but not limited to:

   a. dissatisfaction with plan administration;

   b. appeal of an adverse determination;

   c. the denial, reduction, or termination of a service;

   d. the way a service is provided; or

   e. disenrollment decisions.

   A grievance/complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the **Member**.

B. **Grievance/Complaint Review.**

1. **HMO** will send the **Member** acknowledgment of the grievance/complaint within 5 business days of having received it. The acknowledgment will contain:

   i. the date of receipt of the grievance/complaint;

   ii. a description of **HMO's** grievance/complaint procedures and time frames;

   iii. a one-page complaint form, clearly stating that the grievance/complaint form must be returned to **HMO** for prompt resolution of the grievance/complaint, if the grievance/complaint is received orally;

   iv. requests for the **Member** to provide any additional information to assist **HMO** in handling and deciding the grievance/complaint; and

   iii. a notice informing the **Member** of the **Member's** right to have an uninvolved **HMO** repre-

   sentative assist the **Member** in understanding the grievance/complaint process.

   HMO will acknowledge, investigate, and resolve the grievance/complaint within 30 calendar days from the date of receipt of the written grievance or one-page grievance/complaint form.

2. The Grievance/Complaint Panel deciding the grievance/complaint shall be comprised of one or more employees of **HMO**. It shall not include any person whose decision is being appealed, any person who made the initial decision regarding the claim, or any person with previous involvement with the grievance/complaint.

3. A written notice stating the result of the review by the Grievance/Complaint Panel shall be forwarded by **HMO** to the **Member**. Such notice shall include:

   a. a description of the Panel's understanding of the **Member's** grievance/complaint as presented to the Grievance/Complaint Panel (i.e., dollar amount of the disputed issue, medical facts in dispute, etc.); and

   b. the Panel's decision in clear terms, including the contract basis or medical rationale, as applicable, in sufficient detail for the **Member** to respond further to **HMO's** position (i.e., the **Member** did not contact the **PCP**, the services were non-emergency services as identified in the medical report, the services were not covered by the **Certificate**, etc.); and

   c. citations to the evidence or documentation used as the basis for the decision, including the specialization of any **Provider** consulted (i.e., reference to the **Certificate**, medical records, etc.);

d. if the decision is to deny services based on an adverse determination of **Medical Necessity**, the clinical bases used to reach that decision;

e. that the decision of the Grievance/Complaint Panel shall be final and binding unless appealed by the **Member** to **HMO** within sixty (60) days of the date of the notice of the decision of the Grievance/Complaint Panel; and

f. a full description of the appeals process and the time frames for the final decision on the appeal.

C. **Appeal Hearing.**

1. Upon receipt of a written appeal by the Appeal Panel, **HMO** shall provide the **Member** filing the appeal with an acknowledgment letter within 5 business days. This letter shall contain the procedures governing appeals before the Appeal Panel including the date and location for the **Member** to appear before the Appeal Panel. The appeal process gives the **Member** the opportunity to appear in person before the Appeal Panel or address the **Member's** issues through a written appeal to the Appeal Panel. The **Member** shall be notified of the **Member's** right to have an uninvolved **HMO** representative available to assist the **Member** in understanding the appeal process.

   No less than 5 business days prior to the **Member's** appearing before the Appeal Panel, the **Member** will receive a copy of any documentation to be presented by the **HMO** staff; the specialization of **Physicians** or **Providers** consulted during the review, and the name and affiliation of all **HMO** representatives on the Appeal Panel. The **Member** may respond to this information for the Appeal Panel to consider in the **HMO's** deliberations.

2. The Appeal Panel shall be established by the Board of Directors of the **HMO** and shall be comprised of equal

numbers of non-employee **HMO Members**; **HMO** staff persons not previously involved in the disputed decision; and **Physicians** or **Providers** experienced in the area of care that is in dispute and who are independent of the **Physicians** or **Providers** who made the prior decision that resulted in the **Member's** appeal. If specialty care is in dispute, the appeal panel must include an additional person who is a **Specialist** in the field of care to which the appeal relates.

3. The Appeal Panel shall hold appeal hearings within the **Members** county of residence or the county where the **Member** normally receives the **HMO's** health care services. Another location may be used if in agreement by the **Member** and **HMO**.

4. The **Member** shall have the right to attend the appeal hearing, question the representative of **HMO** designated to appear at the hearing and any other witnesses, including any person responsible for making the prior determination that resulted in the appeal, and present their case. The **Member** shall also have the right to be assisted or represented by a person of the **Member's** choice, and submit written material in support of their grievance. The **Member** may bring a **Physician** or other expert(s) to testify on the **Member's** behalf. **HMO** shall also have the right to present witnesses. Counsel for the **Member** may present the **Member's** case and question witnesses; if the **Member** is so represented, **HMO** may be similarly represented by counsel. The Grievance/Complaint Appeal Panel shall have the right to question the **HMO** representative, the **Member** and any other witnesses.

5. The appeal hearing shall be informal. The Appeal Panel shall not apply formal rules of evidence in reviewing documentation or accepting testimony at the hearing. The Chair of the Appeal Panel shall have the right to exclude

redundant testimony or excessive argument by any party or witness.

6. A written recor . of the appeal hearing shall be made by stenographic transcription. All testimony shall be under oath.

7. Before the record is closed, the Chair of the Appeal Panel shall ask both the **Member** and the **HMO** representative (or their counsel) whether there is any additional evidence or argument which the party wishes to present to the Appeal Panel. Once all evidence and arguments have been received, the record of the appeal hearing shall be closed. The deliberations of the Appeal Panel shall be confidential and shall not be transcribed.

8. The Appeal Panel shall render a written decision within 30 days of the conclusion of the appeal hearing. The decision shall contain:

   a. date of receipt of the oral or written request for appeal;

   b. a statement of the Appeal Panel's understanding of the nature of the grievance/complaint and the material facts related thereto;

   c. the Appeal Panel's decision and rationale, including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision;

   d. a summary of the evidence, including necessary document supporting the decision; and

   e. a statement of the **Member's** right to appeal to the Department of Insurance, with the following toll-free telephone number and complete address of the Department of Insurance:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714 – 9104
1 - 800 - 252 - 3439.

D. **Ongoing Emergency or Denial of Continued Stays for Hospitalization Appeals.**

Investigation and resolution of appeals related to ongoing emergencies or denials of continued stays for hospitalization grievances will be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed 1 business day from the **Member's** request for appeal.

Due to the ongoing emergency or continued hospital stay, and at the **Member's** request, **HMO** shall provide, in lieu of a grievance/complaint appeal panel, a review by a **Provider** not previously involved with the prior decision and is of the same or similar specialty as typically manages the medical condition, procedure or treatment under discussion for review of the appeal. The **Provider** reviewing the appeal may interview the **Member** or the **Member's** designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within 3 days.

E **Exhaustion of Process.**

The foregoing procedures and process are mandatory and must be exhausted prior to:

1. any investigation of a complaint by the Department of Insurance or

2. the filing of a complaint with the Department of Insurance; or

3. the establishing of any litigation or any administrative proceeding regarding either any alleged breach of the

Group Agreement or **Certificate** by **HMO**, or any matter within the scope of the grievance/ complaint resolution process of any complaint, grievance or grievance appeal.

F. **Record Retention.**

HMO shall retain the records of all grievances/complaints for a period of at least 7 years from the date of the receipt of the grievance/complaint. The records will include each grievance/complaint and any grievance/complaint proceeding and any actions taken on a grievance/complaint. A **Member** is entitled to a copy of the record on the applicable grievance/complaint and any grievance/complaint proceeding.

G. **Independent Review Organization (IRO).**

A **Member** whose appeal of an adverse determination is denied by **HMO** has the right to seek review of that determination by an IRO assigned to the appeal in accordance with state law. Not later than the third business day after the date that **HMO** receives a request for review, **HMO** will provide to the IRO the following:

1. any medical records of the **Member** that are relevant to the review;
2. any documents used by **HMO** in making the determination;
3. the written notification of the Appeal Hearing decision provided to the **Member;**
4. any documentation and written information submitted to **HMO** in support of the appeal; and
5. a list of each **Provider** who has provided care to the **Member** and who may have medical records relevant to the appeal.

HMO will comply with the IRO's determination with respect to the **Medical Necessity** or appropriateness of health care items and services for a **Member**, and pay for the independent review.

In a circumstance involving a **Member's** life-threatening condition, the **Member** is entitled to an immediate appeal to an IRO and is not required to comply with procedures for an internal review of **HMO's** adverse determination. A life-threatening condition is a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

H. **Fees and Costs.**

Nothing herein shall be construed to required **HMO** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a grievance/complaint or appeal.

I. **HMO** may not refuse to renew or cancel coverage of the **Contract Holder** or a **Member** or take any other retaliatory action because the **Contract Holder** or a **Member** has filed a grievance/complaint or appealed a decision made by **HMO**. Also, **HMO** may not refuse to renew or terminate a contract with a **Participating Provider** or **Participating Physician** in retaliation for the filing of a grievance/complaint or appeal of a decision made by **HMO**, on behalf of the **Contract Holder** or a **Member**.

COORDINATION OF BENEFITS

Some **Members** have health coverage in addition to the coverage provided under this **Certificate**. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this **Certificate**.

When coverage under this **Certificate** and coverage under another plan applies, the order in which the various plans

will pay benefits must be figured. This will be done as follows using the fast rule that applies:

A. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

B. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

    1. secondary to the plan covering the person as a dependent; and

    2. primary to the plan coveting the person as other than a dependent;

    the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

        1. covers the person as other than a dependent; and

        2. is secondary to Medicare.

C. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

    If the other plan does not have the rule described in this provision (C) but instead has a rule based on the gender of the parent and if, as a result, the plans do not

agree on the order of benefits, the rule in the other plan will determine the order of benefits.

D. In the case of a dependent child whose parents are divorced or separated:

    1. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (C) above will apply.

    2. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

    3. If there is not such a court decree:

    If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

    If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

E. If A, B, C and D above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person as a:

1. laid-off or retired employee; or
2. the dependent of such person,

shall be determined after the benefits of any other plan which covers such person as:

1. an employee who is not laid-off or retired; or
2. a dependent of such person.

If the other plan does not have a provision:

1. regarding laid-off or retired employees; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

1. regarding right of continuation pursuant to federal or state law; and
2. as a result, each plan determines its benefits after the other,

then the above paragraph will not apply.

HMO has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision as permitted by State or Federal law.

Other plan means any other plan of health expense coverage under:

1. Group insurance.
2. Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
3. No-fault and traditional "fault" auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Payment of Benefits.

The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, **HMO** will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of **Allowable Expenses** less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a **Member** covered under this **Certificate** during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this coverage.

The difference between the cost of a private **Hospital** room and the semiprivate rate is not considered an Allowable Expense unless the patient's stay in a private **Hospital** room is **Medically Necessary**, either in terms of generally accepted medical practice or as specifically defined in this **Certificate**.

When the benefits under the plan which determines its benefits first are reduced because a **Member** does not comply with the plan provisions, the amount of such reduction will not be considered an **Allowable Expense**. Examples of such provisions include, but are not limited to, those related to second surgical opinions and certification of admissions or services.

Facility of Payment.

A payment made by another plan may include an amount which should have been paid under this **Certificate**. If it does, **HMO** may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by **HMO**. **HMO** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments.

If the benefits paid under this **Certificate**, plus the benefits paid by other plans, exceeds the total amount of **Allowable Expenses**, **HMO** has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery shall be exercised at **HMO's** discretion. A **Member** shall execute any documents and cooperate with **HMO** to secure its right to recover such overpayments, upon request from **HMO**.

Medicare And Other Federal Or State Government Programs.

The provisions of this section will apply to the maximum extent permitted by federal or state law. **HMO** will not reduce the benefits due any **Member** due to that **Member's** eligibility for Medicare where federal law requires that **HMO** determines its benefits for that **Member** without regard to the benefits available under Medicare.

The coverage under this **Certificate** is not intended to duplicate any benefits for which **Members** are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided pursuant to this **Certificate** shall be payable to and retained by **HMO**. Each **Member** shall complete and submit to **HMO** such consents, releases, assignments and other documents as may be requested by **HMO** in order to obtain or assure reimbursement under Medicare or any other government programs for which **Members** are eligible.

Medicare benefits will be taken into account for any **Member** who is eligible for Medicare. This will be done whether or not the **Member** is enrolled in Medicare.

Active Employees and Their Dependents Who Are Eligible For Medicare.

Certain rules apply to active employees and their **Dependents** who are eligible for Medicare. When a active **Subscriber**, or the **Dependent** of a active **Subscriber**, is eligible for Medicare and the **Subscriber** or **Dependent** belongs to a group covered by this **Certificate** with twenty (20) or more employees, that **Member** must make a written election to the **Contract Holder** indicating whom that **Member** wants to be his primary carrier. If the **Member** elects the **Contract Holder's** group plan as the primary plan, this **Certificate** will be the primary payer. If the **Member** elects Medicare as the primary plan, all benefits otherwise payable to that **Member** under this **Certificate** shall terminate. If the **Member** belongs to a covered group of less than twenty (20) employees, this **Certificate** will be secondary payer and all benefits otherwise payable with respect to the **Member** will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD).

Special rules apply to **Members** who are disabled or who have End Stage Renal Disease. This **Certificate** will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Retired Employees and Their Dependents Who Are Eligible For Medicare.

If the eligible class of employees of this **Certificate** includes coverage for retired employees who are eligible for Medicare, the benefits provided by this **Certificate** will be paid in accordance with the Provision for Coordination with Medicare section below.

Provision for Coordination with Medicare.

Benefits under this **Certificate** will cease for any **Member** eligible for Medicare. If coverage would cease because a **Subscriber** is, or could be, eligible for Medicare or any other Federal or State government programs (such as Worker's Compensation) any benefits in force for the **Subscriber's Covered Dependents** may be continued. Coverage will then continue until it terminates for some other reason under the rules of this **Certificate**. A conversion privilege may be available in the event that a **Dependent's** coverage under this **Certificate** ends because the **Subscriber** becomes eligible for Medicare. This does not apply if the **Member** is eligible for any Medicare related benefits under this **Certificate**.

SUBROGATION

If **HMO** provides health care benefits under this **Certificate** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment of the full cost of all benefits provided by **HMO** on behalf of the **Member** that are associated with the injury or illness for which the third party is or may be responsible. **HMO** receives all rights of recovery acquired by a **Member** against any person or organization for negligence or any willful act resulting in illness or injury covered by the **HMO Covered Benefits**, but only to the extent of these **Covered Benefits**. Upon receiving such **Covered Benefits** from the **HMO**, the **Member** has considered to have assigned such rights of recovery to the **HMO** and to have agreed to give the **HMO** any reasonable help required to secure the recovery. The recovery may include attorney fees and court costs if applicable.

RESPONSIBILITY OF MEMBERS

A. **Members** or applicants shall complete and submit to **HMO** such application or other forms or statements as **HMO** may reasonably request **Members** represent that all information contained in such applications, forms and statements submitted to **HMO** incident to enrollment under this **Certificate** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

B. The **Member** shall notify **HMO** immediately of any change of address for the **Member** or any of the **Member's Covered Dependents**.

C. The **Member** understands that **HMO** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this **Certificate**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

A. **Identification Card.** The identification card issued by **HMO** to **Members** pursuant to this **Certificate** is for identification purposes only. Possession of an **HMO** identification card confers no right to services or benefits under this **Certificate**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Certificate**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Certificate**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Certificate** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Certificate** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's HMO** identification card by any other person, such card may be retained by **HMO**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Certificate** shall be terminated immediately, subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**.

B. **Reports and Records. HMO** is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Certificate** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Certificate**. By accepting coverage under this **Certificate**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim;
2. render reports pertaining to the care, treatment and physical condition of the **Member** to **HMO**, or a medical, dental, or mental health professional that **HMO** may engage to assist it in reviewing a treatment or claim; and
3. permit copying of the **Member's** records by **HMO**.

C. **Refusal of Treatment.** A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **HMO**, will have further responsibility to provide any of the benefits available under this **Certificate** for treatment of such condition or its consequences or related conditions. **HMO** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance/Complaint Procedure set forth in the Grievance/Complaint Procedure section of this **Certificate**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

D. **Assignment of Benefits.** All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

E. **Legal Action.** No action at law or in equity may be maintained against **HMO** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this **Group Agreement**.

No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

F. **Independent Contractor Relationship.**

1. No **Participating Provider** or other **Provider**, institution, facility or agency is an agent or employee of **HMO**. Neither **HMO** nor any **Member** of **HMO** is an agent or employee of any **Participating Provider** or other **Provider**, institution, facility or agency.

2. Neither the **Contract Holder** nor a **Member** is the agent or representative of **HMO**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **HMO** has made or hereafter shall make arrangements for services under this **Certificate**.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all Medical Services which are rendered by **Participating Physicians**.

4. **HMO** cannot guarantee the continued participation of any **Provider** or facility with **HMO**. In

the event a **PCP** terminates its contract or is terminated by **HMO**, **HMO** shall provide notification to **Members** in the following manner:

a within thirty days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and

b. services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the **Provider** Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

5. **Restriction on Choice of Providers:** Unless otherwise approved by **HMO**, **Members** must utilize **Participating Providers** and facilities who have contracted with **HMO** to provide services.

G. **Inability to Provide Service.** In the event that due to circumstances not within the reasonable control of **HMO**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the **Participating Provider** Network, the rendition of medical or **Hospital** benefits or other services provided under this **Certificate** is delayed or rendered impractical, **HMO** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **HMO** on the date such event occurs. **HMO** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

H. **Confidentiality.** Information contained in the medical records of **Members** and information received from **Physicians**, surgeons, **Hospitals** or other **Health Professionals** incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the **Member** except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by **HMO** in connection with the administration of this **Certificate**, or in the compiling of aggregate statistical data.

I. **Limitation on Services.** Except in cases of a **Medical Emergency**, as provided under the **Covered Benefits** section of this **Certificate**, services are available only from **Participating Providers**. **HMO** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **HMO**.

J. **Incontestability.** In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. During the first two years, coverage can be voided for material misrepresentation contained in a written application. After two years, coverage can be voided only in the event of a fraudulent misstatement contained in the written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

K. This **Certificate** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

L. **Contract Holder** hereby makes **HMO** coverage available to persons who are eligible under the Eligibility and Enrollment section of this **Certificate**. However, this **Certificate** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Insurance. This can also be done by mutual written agreement between **HMO** and **Contract Holder** without the consent of **Members**.

M. **HMO** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Certificate**.

N. No agent or other person, except an authorized representative of **HMO**, has authority to waive any condition or restriction of this **Certificate**, to extend the time for making a payment, or to bind **HMO** by making any promise or representation or by giving or receiving any information. No change in this **Certificate** shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

O. This **Certificate**, including the Schedule of Benefits, any Riders, and any amendments, inserts, or attachments, constitutes the entire **Certificate** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of this **Certificate** shall be binding unless executed in writing by authorized representatives of the parties.

P. If this **Certificate** contains any provision not in conformity with Texas state law or other applicable laws it

shall not be rendered invalid but shall be construed and applied as if it were in full compliance according to applicable Texas state law and other applicable laws.

DEFINITIONS

The following words and phrases when used in this **Certificate** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Actively at Work.** The condition where an employee is performing all of the **Subscriber's** regular duties for the **Contract Holder** (the **Subscriber's** employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be considered to be actively at work on a non-scheduled work day only if such person is actively at work on the last regularly scheduled work day immediately preceding such non-scheduled work day.
- **Allowable Expense.** Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the **Member** for whom claim is made.
- **Behavioral Health Provider**. A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.
- **Certificate**. This **Certificate** of Coverage, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.
- **Chemical Dependency**. The abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

- **Chemical Dependency Rehabilitation.** Services, procedures and interventions to eliminate the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance, according to individualized treatment plans.
- **Contract Holder**. An employer or organization who agrees to remit the **Premiums** for coverage under the **Group Agreement** payable to **HMO**. The **Contract Holder** shall act only as an agent of **HMO Members** in the **Contract Holder's** group, and shall not be the agent of **HMO** for any purpose.
- **Contract Year.** A period of one year commencing on the **Contract Holder's Effective Date of Coverage** and ends at 12:00 midnight on the last day of the one year period.
- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first Refer to the Coordination of Benefits section of this **Certificate** for a description of the **Coordination of Benefits** provision.
- **Copayment**. A specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the Schedule of Benefits. **Copayments** may be changed by **HMO** upon 30 days written notice to the **Contract Holder**.

- **Copayment** Maximum. The maximum annual out-of-pocket amount for payment of **Copayments**, if any, to be paid by a **Subscriber** and any **Covered Dependents**, if any.
- **Cosmetic Surgery**. Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.
- **Covered Dependent**. Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Certificate** and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements set forth in the Premiums section of the **Group Agreement**.
- **Covered Benefits.** Those **Medically Necessary Services** and supplies set forth in this **Certificate**, which are covered subject to all of the terms and conditions of the **Group Agreement** and **Certificate**.
- **Creditable Coverage.** Coverage of the **Member** under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program

(FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. **Creditable Coverage** does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital **Skilled Nursing Facility** care; or c) is a level such that the **Member** has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement **Custodial Care** includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the **Member's** daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the **Member**, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of **HMO**, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and

adult day care, protective and supportive care including educational services, rest cures, convalescent care.

- **Detoxification**. The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.
- **Durable Medical Equipment**. Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.
- **Effective Date of Coverage.** The commencement date of coverage under this **Certificate** as shown on the records of **HMO**.
- **Emergency Service.** Professional health services that are provided to treat a **Medical Emergency**.
- **Experimental or Investigational Procedures**. Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
  7. it is provided or performed in special settings for research purposes.

- **Group Agreement**. The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group Application, Cover Sheet, this **Certificate**, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.
- **Health Professionals**. A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services**

which are within the scope of the individual's license or certificate.

- **HMO**. Aetna U.S. Healthcare of North Texas Inc., a Texas corporation licensed by the Texas Department of Insurance as a Health Maintenance Organization.
- **Homebound Member**. A **Member** who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the **Member's** ability to leave the **Member's** place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.
- **Home Health Services**. Those items and services provided by **Participating Providers** as an alternative to hospitalization, and approved and coordinated in advance by **HMO**.
- **Hospice Care**. A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **HMO**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.
- **Hospital**. An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **HMO** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.
- **Infertile or Infertility**. The condition of a presumably healthy **Member** who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does

not include conditions for male **Members** when the cause is a vasectomy or orchiectomy or for female **Members** when the cause is a tubal ligation or hysterectomy.

- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.
- **Medical Emergency**. The recent onset of a medical condition of severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
  1. placing the patient's health in serious jeopardy,
  2. serious impairment to bodily functions;
  3. serious dysfunction of any bodily organ or part;
  4. serious disfigurement; or
  5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

  Some examples of **Medical Emergencies** include heart attacks, convulsions, serious burns, poisoning, loss of consciousness, injuries involving treatment to the mouth and teeth, and conditions that have progressed from a non-emergent situation initially to that of an emergent nature over a period of time, of a few days to as long as a week.
- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.
- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate

and consistent with the diagnosis in accordance with accepted medical standards as described in the **Covered Benefits** section of this **Certificate**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **Certificate**.

- **Member**. A **Subscriber** or **Covered Dependent** as defined in this **Certificate**.
- **Mental or Behavioral Condition.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to, psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral, or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.
- **Mental Health Treatment Facility:** A facility that: a) meets licensing standards; b) mainly provides a program for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medical services that may be

required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.
- **Open Enrollment Period**. A period of not less than 31 days, per calendar year, when eligible enrollees of the **Contract Holder** may enroll in **HMO** without a waiting period or exclusion or limitation based on health status or, if already enrolled in **HMO**, may transfer to an alternative health plan offered by the **Contract Holder**. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month, except that if the month is February, the period shall last through March 2.
- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.
- **Participating**. A description of a **Provider** that has entered into a contractual agreement with **HMO** for the provision of services to **Members**.
- **Physician**. A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and

who provides **Medical Services** which are within the scope of the individual's license or certificate.

- **Premium**. The amount the **Contract Holder** or **Member** is required to pay to **HMO** to continue coverage.
- **Primary Care Physician**. A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.
- **Provider**. A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital**, or **Medical Services** to **Members**.
- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the **HMO** to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. **HMO** may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
- **Referral**. Specific directions or instructions from a **Member's PCP**, in conformance with **HMO's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.
- **Respite Care**. Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

- **Serious Mental Illness**: means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- **Service Area**. The geographic area, established by **HMO** and approved by the appropriate regulatory authority.
- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.
- **Skilled Nursing Facility**. An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the Americ .n Osteopathic Association, or as otherwise determined by **HMO** to meet the reasonable standards applied by any of the aforesaid authorities.
- **Specialist**. A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.
- **Subscriber**. A person who meets all applicable eligibility requirements as described in this **Certificate** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the **Premiums** section of the **Group Agreement**.

- **Totally Disabled or Total Disability**. A **Member** shall be considered Totally Disabled if:

  1. the **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or

  2. the **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

[CERTIFICATE OF COVERAGE AMENDMENT]

* * * *

COVERED BENEFITS

The following is added to Section B of the Covered Benefits section of the **Certificate**:

4. **Osteoporosis Benefits**. Bone mass measurement by a **Participating Provider** to determine a **Qualified Individual's** risk of osteoporosis and fractures associated with osteoporosis is covered. The Member is required to obtain a **Referral** from his or her **PCP**, or obtain prior authorization from **HMO** to a **Participating Provider**, prior to receiving this benefit.

   A **Copayment** and a maximum annual out-of-pocket payment, may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

The following replaces Section G of the Covered Benefits section of the **Certificate**:

G. **Transplants**.

Transplants which are non-experimental or non-investigational are a **Covered Benefit**. Covered transplants must be ordered by the **Member's PCP** and **Participating Specialist Physician** and approved by **HMO's** Medical Director in advance of the surgery. The transplant must be performed at **Hospitals** specifically approved and designated by **HMO** to perform these procedures. A transplant is non-experimental and non-investigational hereunder when **HMO** has determined, in its sole discretion, that the **Medical Community** has generally accepted the procedure as appropriate treatment for the specific condition of the **Member**. Coverage for a transplant where a **Member** is the recipient includes coverage for the medical and surgical expenses of a

live donor, to the extent these services are not covered by another plan or program. The **Member** will not be required to travel out-of-state to receive transplant services unless the **HMO** obtains the informed consent of the **Member**.

The following replaces Section L of the Covered Benefits section of the **Certificate**:

L. **Rehabilitation Benefits**.

A **Member** is covered for rehabilitative services and physical, speech and occupational therapies that, in the opinion of a **Participating Physician**, are **Medically Necessary** if they meet or exceed treatment goals for the **Member**. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

The following replaces Section R of the Covered Benefits section of the **Certificate**:

R. **Benefits for Temporomandibular Joint Disorders (TMJ).**

Benefits for TMJ will be provided when preauthorized by **HMO**. This includes diagnostic and surgical treatment of TMJ that is **Medically Necessary** as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology. All provisions applicable to other illness and surgical treatment, including **Copayments**, under the **HMO** will apply to benefits for TMJ. For purposes of this benefit, the temporomandibular joint includes the jaw and the craniomandibular joint.

The following is added to Section T of the Covered Benefits section of the **Certificate**:

- **Reconstructive Breast Surgery Benefits**. Reconstructive breast surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including aereolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and medically necessary physical therapy to treat the complications of mastectomy, including lymphedema.

A **Copayment** and a maximum annual out-of-pocket payment, may apply to this service. Refer to the Schedule of Benefits attached to this **Certificate**.

EXCLUSIONS AND LIMITATIONS

The following replaces the cosmetic surgery exclusion of the Exclusions and Limitations section of the Certificate:

- **Cosmetic Surgery**, or treatment relating to the consequences of, or as a result of, **Cosmetic Surgery**, other than **Medically Necessary Services**. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an **HMO** Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. This exclusion also does not apply to breast reconstruction following a mastectomy, including the breast

on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed.

TERMINATION OF COVERAGE

The following replaces Section A.3 of the Termination of Coverage section of the **Certificate**:

1. the **Subscriber** is no longer eligible as outlined on the Schedule of Benefits or this **Certificate**; or

The following replaces Section B.1 of the Termination of Coverage section of the Certificate:

1. a **Covered Dependent** is no longer eligible, as outlined on the Schedule of Benefits or this **Certificate**;

The following replaces Section C.3 of the Termination of Coverage section of the **Certificate**:
upon 15 days advance written notice, upon discovering a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Certificate** or discovering that the **Member** has committed fraud against **HMO**, including fraud in the use of services or facilities. This may include, but is not limited to, furnishing incorrect or misleading information to **HMO**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **HMO** benefits. In the absence of fraud, all statements made by a **Subscriber** applying for coverage under this **Certificate** will be deemed representations and not warranties. Coverage can be voided for fraud or intentional misrepresentation contained in a written application. A copy of the written application must be furnished to the **Subscriber** if the terms of the application or enrollment form are to be applied.

CONTINUATION AND CONVERSION

The following replaces Section A.4 of the Continuation and Conversion section of the **Certificate**:

4. Continuation coverage under this **Certificate** ends at the earliest of the following events:

   a. the last day of the 18-month period.

   b. the last day of the 36-month period.

   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.

   d. the first day on which the **Group Agreement** between **Contract Holder** and **HMO** is not in full force and effect.

   e. the first day on which the **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.

   f. the date the **Member** is entitled to Medicare.

The following is added as Section B.3 to the Continuation and Conversion section of the Certificate:

3. **Texas Health Insurance Risk Pool**

   A **Member** may be eligible for coverage under the Texas Health Insurance Risk Pool. Prior to the end of the **Member's** coverage under the "Continuation of Coverage—State of Texas" section of this **Certificate**, **HMO** will provide the **Member** with the Texas

Health Insurance Risk Pool's address and toll-free telephone number.

Coverage provided under this Amendment may be terminated in accordance with the provisions stated in the "Termination of Coverage" section of the **HMO Certificate of Coverage**, including, but not limited to, payment of the required **Premium** for this benefit.

This Amendment shall not vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the **HMO Certificate of Coverage**, other than as stated above.

GENERAL PROVISIONS

The following replaces Section J of the General Provision section of the **Certificate**:

J. **Incontestability**. In the absence of fraud, all statements made by **Subscriber** are considered representations and not warranties. Coverage can be voided for fraud or intentional misrepresentation contained in a written application. A copy of the written application must have been furnished to the **Subscriber** if the terms of the application or enrollment forms are to be applied.

AETNA U.S. HEALTHCARE
OF NORTH TEXAS INC.
(TEXAS)

INPATIENT MENTAL HEALTH RIDER

Contract Holder Group Agreement Effective Date: December 1, 1999

Aetna U.S. Healthcare of North Texas Inc., ("**HMO**") and **Contract Holder** agree to offer to **Members** the HMO inpatient Mental Health benefit, subject to the following provisions:

The Definitions section of the **Certificate** is amended to include the following definitions:

Crisis Stabilization Unit: A 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions, and which is provided by a facility that is licensed or operated by the appropriate state agency or board to provide such services.

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Mental Health Treatment Facility: A facility that: a) meets licensing standards; b) mainly provides a program. for diagnosis, evaluation and treatment of acute mental or nervous disorders; c) prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs; d) provides all normal infirmary level medical services or arranges with a **Hospital** for any other medi-

cal services that may be required; e) is under the supervision of a psychiatrist; and f) provides skilled nursing care by licensed nurses who are directed by a registered nurse.

Partial Hospitalization: The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

Residential Treatment Center. A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, Healthcare Operations, or the American Association of Psychiatric Services for Children, and which is licensed or operated by the appropriate state agency or board to provide such services.

Section J of the Covered Benefits section of this **Certificate** is amended to add the following provisions:

3. Inpatient benefits are covered for medical, nursing, counseling or therapeutic services in an inpatient, **Hospital** or non-hospital residential facility including a **Mental Health Treatment Facility, Crisis Stabilization Unit**, or **Residential Treatment Center** appropriately licensed by the Department of Health or its equivalent. Coverage is subject to the maximum number of days, if any, shown on the below, however **Coverage** will not be less favorable

than for hospital coverage under your particular plan of benefits.

Inpatient benefit exchanges are a **Covered Benefit**. When authorized by **HMO**, 1 mental health inpatient day, if any, may be exchanged for up to 2 outpatient or home health visits up to the maximum benefit limitation upon approval by **HMO**.

One (1) inpatient day, if any, may be exchanged for 2 days of treatment in a **Partial Hospitalization** and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by **HMO**.

Requests for a benefit exchange must be initiated by the **Member's Participating Behavioral Health Provider** under the guidelines set forth by the **HMO**. **Member** must utilize all outpatient mental health benefits, if any, available under the **Certificate** and pay all applicable **Copayments** before an inpatient and outpatient visit exchange will be considered. The **Member's Participating Behavioral Health Provider** must demonstrate **Medical Necessity** for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by **HMO** prior to utilization.

Benefits are in conjunction with the **Member's Individual Treatment Plan**.

Copayment
The **Member** is responsible for a **Copayment** and Maximums as follows:

$500 per admission

Maximum of 30 days per Contract Year

MISCELLANEOUS PROVISIONS

Section C of the Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

Inpatient Mental Health - The conversion privilege does not apply to the HMO Inpatient Mental Health benefit.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC. (TEXAS)

PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date: December 1, 1999

Aetna U.S. Healthcare of North Texas Inc. ("**HMO**") and **Contract Holder** agree to offer to **Members** the **HMO** Prescription Plan, subject to the following provisions:

The Definitions section of the **Certificate** is amended to include the following definitions:

- **Brand Name Prescription Drug(s) or Medicine(s)** - A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **HMO** or an affiliate. **Brand Name Prescription Drugs or Medicines** do not include those drugs classified as **Generic Prescription Drugs or Medicines** as defined below.
- **Contracted Rate** - The negotiated rate between **HMO** or an affiliate and the **Participating Pharmacy**.
- **Drug Formulary** - A listing of prescription medications established by **HMO** or an affiliate. This list is distributed to **Participating Providers** and is subject to periodic review and modification by **HMO** or an affiliate. An updated copy of the **Drug Formulary** shall be available at any time upon request by the **Member**. A **Drug Formulary** may be managed as "closed", "open", or "differential copay" based upon the benefit design of the **Member's HMO** Prescription Plan.
- **Generic Prescription Drug(s) or Medicine(s)** - A prescription drug, whether identified by its chemical,

proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

- **Maintenance Drugs** - A listing of prescription drugs or medications established by **HMO** or an affiliate which is subject to periodic review and modification by **HMO** or an affiliate. The list consists of prescription drugs or medications that are taken for extended periods of time, and which do not vary frequently in terms of dosage (such as high blood pressure medication).
- **Participating Mail Order Pharmacy** - An establishment which has contracted with **HMO** or an affiliate, and where prescription drugs or medicines are legally dispensed by mail.
- **Participating Pharmacy** - A community pharmacy which has contracted with **HMO** or an affiliate to provide prescription services to **Members**.

A. **Outpatient Prescription Triple Copayment Benefit**.

1. Outpatient prescription drugs or medicines are covered when prescribed by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. The list of covered prescription drugs or medicines is subject to change from time to time at the sole discretion of **HMO**. Except for **Maintenance Drugs** as indicated below, each prescription is limited to a maximum 34 day supply, with up to a refills when authorized by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. Prescriptions must be filled at a **Participating Pharmacy**.

   The **Member's Copayment** is based on the usage or non-usage of **HMO's** or an affiliate's **Drug Formulary**, which includes both **Brand Name Prescription Drugs or Medicines** and **Generic Prescription Drugs or Medicines** approved by **HMO** or an affiliate.

Prescription drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

The **Member** is responsible for a **$10 Copayment** per prescription or refill for a **Generic Prescription Drug or Medicine**.

The **Member** is responsible for a **$15 Copayment** per prescription or refill for a **Brand Name Formulary Prescription Drug or Medicine**.

The **Member** is responsible for a **$30 Copayment** per prescription or refill for a **Brand Name non-Formulary Prescription Drug or Medicine**.

The **Copayment** is payable directly to the **Participating Pharmacy** for each prescription at the time the prescription is dispensed. The **Copayment** is not subject to the Annual Maximum Out-of-Pocket Limit set forth in the Schedule of Benefits, if any.

2. Coverage for **Maintenance Drugs**, beyond the 34-day supply, is available under this Prescription Plan benefit. To be covered on this extended basis, the prescription drug must be a **Maintenance Drug** on the list of drugs approved by **HMO** or an affiliate and appropriate for the **Member's** illness or injury. The prescription must be originally filled for up to a 34 day supply by the **Participating Pharmacy** and be covered under this Rider. Thereafter the **Maintenance Drug** is covered for up to a 90 day supply upon a written prescription by a **Provider** licensed to prescribe federal legend prescription drugs or medicines provided the strength or form is not changed. If the prescription is not refilled within 45 days after total utilization based upon the **Provider's** prescribed directions, the next refill will be considered an initial prescription, and will be covered up to a maximum 34 day supply. All 90 day supply prescriptions must be filled by the **Participating Pharmacy**. This list is subject to change in **HMO's** or an affiliate's sole discretion, without notice to **Members** or **Contract Holder**.

   Copayment: **If the Member obtains more than a 34-day supply of prescription drugs or medicines, not to exceed a 90-day supply, two Copayments are payable for each supply dispensed.**

B. **Emergency Prescriptions Out-of-Area** - If an emergency prescription is needed when the Member is located beyond a 50-mile radius from the **HMO Service Area**, **HMO** will reimburse, subject to professional review, the cost of the prescription, less the **Copayments** specified in Section A above if a non-participating pharmacy is used. If the Member uses a **Participating Pharmacy** located outside the **HMO Service Area**, the

Member will be subject to the **Copayment** listed in Section A above.

C. **Additional Optional Benefits**.

The following prescription drugs, medicines, and supplies are also covered:

- **Contraceptives.**

  The following contraceptives and contraceptive devices are covered upon prescription or upon the **Participating Physician's** order only at a **Participating Pharmacy**:

  1. Diaphragms, one per 365 day period.
  2. Depo provera. The prescription plan **Copayment** applies for each vial up to a maximum of 5 vials per 365 consecutive day period.
  3. Norplant and IUDs are covered when obtained from a Participating **Physician**. The **Participating Physician** will provide insertion and removal of the device. An office visit **Copayment** will apply, if any.

- **Mail Order Prescription Drugs and Medicines**. Outpatient prescription drugs or medicines are covered when dispensed by a licensed **Participating Mail Order Pharmacy** and require a prescription drug or medicine order by a **Provider** licensed to prescribe federal legend prescription drugs or medicines. Outpatient prescription drugs and medicines will not be dispensed in quantities that are less than a 34 day supply or more than a ninety (90) day supply.

The **Member** is responsible for the **Copayment** listed in Section A above for prescription drugs or medicines dispensed by a **Participating Mail Order Pharmacy**. The **Copayment** is payable directly to the **Participating Mail Order Pharmacy** for each dispensed order. The **Copayment** is not subject to the Annual Maximum Out-of-Pocket Limit set forth in the Schedule of Benefits, if any.

Copayment: If the Member obtains more than a 34-day supply of prescription drugs or medicines, not to exceed a 90-day supply, two Copayments are payable for each supply dispensed.

The Limitations and Exclusions section of the **Certificate** is amended to include the following limitations and exclusions:

A. **Exclusions**.

Unless specifically covered under this Rider, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug even when a prescription is written.)
2. Any charges for the administration of prescription legend drugs and other injectable drugs covered by **HMO**.
3. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to, Retin A for wrinkles, health and beauty aids.
4. Needles and syringes.
5. Any medication which is consumed or administered at the place where it is dispensed, except when dispensed and consumed at a **Participating Pharmacy**.
6. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or

other blood products administered on an outpatient basis, allergy sera and testing materials.
7. Drugs used for the purpose of weight reduction (i.e. appetite suppressants).
8. Any prescription drug for which the actual charge to the recipient is less than the required **Copayment** or which applies to the Deductible Amount or for any drug for which no charge is made to the recipient.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, **HMO** may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than one (1) year from the date the latest prescription order was written; or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
13. Test agents and devices.
14. Smoking cessation aids.
15. Injectable drugs used for the purpose of treating infertility.
16. Injectables.
17. Non-oral and implantable contraceptive drugs and contraceptive devices.
18. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this Rider.

B. **Limitations**:

A **Participating Pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Section C of the Continuation and Conversion section of the **Certificate** is hereby amended to include the following provision:

The conversion privilege does not apply to the **HMO** Prescription Plan.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

AMENDMENT TO THE PRESCRIPTION PLAN RIDER

Contract Holder Group Agreement Effective Date:
December 1, 1999

The Aetna U.S. Healthcare Inc. Prescription Plan Rider is hereby amended as follows:

The Exclusions and Limitations section of the Prescription Plan Rider is hereby amended to include the following exclusion:

19. Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy, including but not limited to, sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms, any prescription drug in oral or topical form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
20. Performance, athletic performance or lifestyle enhancement drugs and supplies.
21 Drugs and supplies when not indicated or prescribed for a medical condition as determined by **HMO**.

AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.
(TEXAS)

SCHEDULE OF BENEFITS

Plan Name: CITIZEN PLAN
Contract Holder Name: Monitronics International Inc
Contract Holder Group Agreement Effective Date:
December 1, 1999
Contract Holder Number: 148028
Contract Holder Locations: 001
Contract Holder Service Areas: TX01

OUTPATIENT BENEFITS

Benefit	Copayment
Primary Care Physician Office Visit	
During Office Hours	**$15 per visit**
Non-Office Hours and Home Visits	**$20 per visit**
Well Child Care	**$15 per visit**
Specialist Physician Office Visit	**$25 per visit**
Outpatient Rehabilitation Benefits	**$25 per visit**
First OB Visit	**$25 per visit**
Routine Gynecological Exam(s)	
1 visit(s) per 365-day period	**$25 per visit**
Hospital Outpatient Department Visit and Diagnostic Testing	**$25 per visit**
Outpatient Emergency Services	
Hospital Emergency Room or Outpatient Department	**$50 per visit**
Ambulance	**$0 per trip**
Outpatient Mental Health Visits	
20 visits per calendar year	**$25 per visit**
Outpatient Serious Mental Illness Visits	
60 maximum visits per calendar year	**$25 per visit**

Benefit	Copayment
Outpatient Chemical Dependency Visits	
Detoxification and Rehabilitation	**$25 per visit**
Subject to the same Copayment as for physical illness.	
Three Treatment Episodes for inpatient hospital and treatment facility, **Partial Hospitalization** and outpatient treatment in a **Member's** lifetime. A "Treatment Episode" is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. A Treatment Episode is complete when the **Member** is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, **Partial Hospitalization** or intensive outpatient or a series of these levels of treatments without a lapse in treatment; or when a **Member** fails to materially comply with the treatment program for a period of 30 days.	
Outpatient Surgery	**$100 per visit**
Outpatient Home Health	**$0 per visit**
Hospice Visits	
365 visits per calendar year	**$0 per visit**
Injectable Medications	**$15 per item**

INPATIENT BENEFITS

Benefit	Copayment
Acute Care **Serious Mental Illness** Maximum of **45** days per calendar year **Maternity** **Skilled Nursing Facility** Maximum of 365 days per calendar year **Hospice** **Chemical Dependency-Detoxification and Rehabilitation** Subject to the same Copayment as for physical illness. Three Treatment Episodes for inpatient hospital and treatment facility, **Partial Hospitalization** and outpatient treatment in a **Member's** lifetime. A "Treatment Episode" is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. A Treatment Episode is complete when the **Member** is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, **Partial Hospitalization** or intensive outpatient or a series of these levels of treatments without a lapse in treatment; or when a **Member** fails to materially comply with the treatment program for a period of 30 days.	**$500 per admission**

ADDITIONAL BENEFITS

Benefit	Copayment
Routine Eye Exam as per schedule in certificate	**$25 per visit**
Durable Medical Equipment Benefits:	
Copayment	**$0 per item**
Maximum Annual Out-of-Pocket	**$0 per Member, per Contract Year**
Maximum Annual Benefit	**Unlimited per Member, per Contract Year**

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

FILED
U.S. DISTRICT COURT
NORTHERN DISTRICT OF TX.
FT. WORTH DIVISION

2001 MAR -9 PM 2:15

CLERK OF COURT

JUAN DAVILA	§	
	§	
Plaintiff,	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
v.	§	
	§	
AETNA U.S.	§	Plaintiff's Response to
HEALTHCARE, INC.	§	Aetna's Motion to Dismiss
AND AETNA U.S.	§	and Plaintiff's Reply to
HEALTHCARE OF	§	Aetna's Response to Plain-
NORTH TEXAS, INC.,	§	tiff's Motion to Remand, And
	§	Brief in Support Thereof
Defendants.	§	

PLAINTIFF'S RESPONSE TO AETNA'S MOTION TO DISMISS AND PLAINTIFF'S REPLY TO AETNA'S RESPONSE TO PLAINTIFF'S MOTION TO REMAND, AND BRIEF IN SUPPORT THEREOF

March 9, 2001

George Parker Young
State Bar No. 22184750
Adam J. Williams
State Bar No. 24013753

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[Pages 5-6]

* * * *

Despite the dubiousness of *Corcoran*'s continued validity, Plaintiff would understand if this Court chose to leave it to a higher court to determine that *Corcoran* is no longer valid law, particularly in light of the cases Aetna cites which rely on *Corcoran* or on its now-faulty analysis that a "mixed medical decision" equals a benefits-denial.[5] If this Court denies Plaintiff's Motion to Remand, it should also dismiss this case *sua sponte* in order to permit this matter to be immediately appealed since Plaintiff *will not* be amending to add ERISA claims for denied benefits—such a claim would violate Fed. R. Civ. Pro. 11 as a frivolous claim, since Mr. Davila's claim is not based on something that was denied, but what he received. But Plaintiff wants to be clear: this

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[5] *See, e.g., Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999); *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996). As demonstrated herein, however, none of the cases cited by Defendants address the fundamental change in ERISA preemption analysis instigated by the Supreme Court trilogy, nor address *Pegram* or the legislative history of the Federal HMO Act.

Court can appropriately rule that *Corcoran*'s mixed-decision analysis is now flawed in light of *Pegram*, and remand based on a lack of subject matter jurisdiction.[6]

* * * *

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6 *See* Plaintiff's Appendix in Support of Plaintiff's Motion to Remand, Exhibits 1-11 (Northern District decisions remanding similar claims). The mischief wrought by confusing conflict and complete preemption is addressed in *Giles v. NYLCare*, 172 F.3d 332, 338 (5th Cir. 1999), where Justice Smith admits the Court got it wrong in *Burks v. Amerada Hess*, 8 F.3d 301 (5th Cir. 1993) which held that a court cannot remand claims which are merely conflict preempted.

The problem with remanding this matter is that it puts off for another day presenting a case to the Fifth Circuit which squarely demands that it overrule *Corcoran*, which was decided at the height of ERISA preemption, before the Supreme Court and Fifth Circuit radically revamped the ERISA preemption analysis.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

U.S. District Court
Northern District of Texas
FILED

MAR-9 2001
CLERK, U.S. DISTRICT COURT
By_____
Deputy

JUAN DAVILA	§	
	§	
Plaintiff,	§	CIVIL ACTION NO.
	§	400-CV-1855-Y
v.	§	
	§	
AETNA U.S.	§	Plaintiff's Second Appendix
HEALTHCARE, INC.,	§	In Support of Remand
ET AL.,	§	
	§	
Defendants.	§	

PLAINTIFF'S SECOND APPENDIX IN SUPPORT OF REMAND

March 9, 2001

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[EXHIBIT 2: Aetna Inc. and Aetna U.S. Healthcare Inc.'s Memorandum of Law in Support of Defendants' Motion to Dismiss the First Amended Complaint, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

[Pages 17-19]

* * * *

State regulation of HMOs is even more extensive. As relevant to the states in which the named Plaintiffs reside, neither the Texas nor Mississippi Department of Insurance will grant a certificate of authority to an HMO unless it has met standards relating to both its rates and its disclosure documents. Thus, Texas law allows the cost-containment practices challenged by Plaintiffs, while regulating them to ensure they do not have the detrimental effects alleged. For example, Texas law "does not prohibit the use of capitation as a method of payment." TEX. INS. CODE art. 20A.14(k)(1). Indeed, Texas law regulates capitation extensively to assure that amounts are "sufficient to compensate the primary care physician . . . for the risk being assumed" and do not result in the denial of necessary medical services. *Id.* art. 20A.18A(e)(4). Texas law further allows utilization to determine whether requested medical services are indeed medically necessary, *see id.* art. 2A.02(a), and specifically contemplates the use of third-party utilization review agents, *see id.* art. 21.58A(3)(a).

The disclosure requirement of Texas's HMO-certification rules requires managed-care companies to file with the Department of Insurance ("DOI") a copy of the certificates of coverage to be provided to enrollees, as well as copies of group contract materials provided to purchasers of coverage, copies of all "contract[s] made or to be made between any provider [or] physician" and the managed care company, and

"a written description of the types of compensation arrangements" used by the company. *Id.* art. 20A.04(a0(4)-(6), (15). The DOI must deny a certificate of authority to any managed-care company whose filed documents are in any way "unjust, unfair, inequitable, misleading, deceptive, [or] which encourage misrepresentation." *Id.* arts. 20A.09(a)(3)(A). Finally, managed care companies must file their rate methodologies with the DOI. *See id.* arts. 20A.09(k). The rate methodologies must produce charges that are not "excessive, inadequate, or unfairly discriminatory," *id.*, and the DOI may disapprove rates that do not meet these statutory standards. *See id.* art. 20A.09(*l*).[8]

Like Texas law, the Mississippi certification requirement for HMOs contains both substantive and disclosure components. Substantively, Mississippi law expressly permits the categories of practices challenged by Plaintiffs. It permits capitation, *see* MISS. CODE ANN. § 83-41-325, and authorizes managed-care companies to use outside private utilization-review firms. *See id.* §§ 41-83-1, 41-83-3, 41-83-5.[9] The

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8 When making a rate adequacy determination, the Insurance Commissioner must consider information about, *inter alia*, "the cost of health care services and benefits provided by the coverage if the same coverage were provided on a private pay basis, considering community average rates for such services and benefits within the service area of the plan," administrative expenses, assumed or actual utilization levels, and group demographics. 28 TEX. ADMIN. CODE § 11.706(b).

9 Managed care plans must submit a summary of their utilization review policy for the State's review. MISS. CODE ANN. § 83-41-409(a)(ii). In addition, utilization review agents themselves are subject to specific requirements. Such third parties must apply for state certification by submitting to the Department of Insurance "a description of review criteria, standards, and procedures" for evaluating requests for medical care. *Id.* § 41-83-9.

disclosure component of Mississippi's managed-care-certification rules requires that all health-maintenance contracts, certificates, and member handbooks—the very "disclosure documents" on which Plaintiffs rest their allegations of nondisclosure and misrepresentation (*see* Compl. ¶ 7)—be submitted to the Insurance Commissioner for prior approval. *See* MISS. CODE ANN. § 83-41-305(3)(3). Managed-care companies are also required to file their proposed rates with the Commissioner for prior approval. *See id.* § 83-41-331. As with misleading "disclosure documents," the Commissioner is required to disapprove any rate schedule that is "excessive, inadequate or unfairly discriminatory." *Id.* § 83-41-331(2).

* * * *

[Pages 38-40]

C. The McCarran-Ferguson Act Pre-Empts The Complaint's RICO Claims

The McCarran-Ferguson Act pre-empts federal civil RICO claims where "RICO's application to the . . . claims at issue [would] 'invalidate, impair, or supersede' [state] laws regulating insurance." *Humana, Inc. v. Forsyth*, 119 S. Ct. 710, 716 (1999) (quoting 15 U.S.C. § 1012(b)). RICO impairs state laws regulating insurance if its application in a particular case would "frustrate any state policy" or "interfere with a State's administrative regime." *Id.* at 719. Because those consequences would plainly ensue here were this Court to entertain Plaintiffs' RICO challenge, that challenge is barred by the McCarran-Ferguson Act.

That point is evident from even a brief overview of the regulatory regime applicable to managed care companies in

Texas, where Plaintiff O'Neill resides. The Texas Commissioner of Insurance has directed what information insurers should disclose to current or prospective HMO enrollees.[18] The Plaintiffs, however, ask this Court to find that disclosures that have been approved by the Commissioner amount to fraud, extortion and other federal crimes actionable under civil RICO. Texas has expressly authorized insurers to enter into contracts that give physicians financial incentives to provide cost-effective care. TEX. INS. CODE art. 20A.14(k)(1); *id.* art. 20A.18A(e)(4). But the Plaintiffs ask this Court to find those same contracts to be extortionate under RICO.

Similarly, Texas, like many other states, reviews insurers' rate methodologies to insure that they are neither excessive nor inadequate in light of the coverage being provided and other relevant circumstances, thus fulfilling the traditional state regulatory goal of assuring that customers will be charged fair rates that are also sufficient to preserve the solvency of the insurer. *See id.* art. 20A.09(k)-(*l*); *see also* 28 TEX. ADMIN. CODE § 11.706(b). Yet the entire point of Plaintiffs' RICO suit is to establish that the rates charged are *un*reasonable in light of the true value of "coverage" actually provided. In short, Plaintiffs RICO claims call into question virtually every aspect of the state's regulatory structure and seek, as their very object, to supplant that structure with a set of judicially-imposed disclosure duties and rate methodologies. The McCarran-Ferguson Act precludes precisely such

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[18] TEX. INS. CODE ANN. § 20A.11(b) (West Supp. 1999); *see also* 28 TEX ADMIN. CODE § 11.506(1)-(26); *id.* § 11.1600(b)(1)-(12).

RICO claims. *See LaBarre v. Credit Acceptance Corp.*, 175 F.3d 640, 643 (8th Cir. 1999).[19]

VII. THE COMPLAINT FAILS TO STATE ANY COGNIZABLE ERISA CLAIM

Plaintiffs also rehash their RICO allegations under ERISA, claiming that Aetna breached its statutory duties to Plaintiffs by failing to disclose how Aetna implements the cost-containment practices that characterize managed care. As Plaintiffs see it, a managed-care provider has "fiduciary" obligations under ERISA to disclose its physician compensation arrangements and other cost-containment practices to all of its members and potential members, regardless of circumstance. (Compl. ¶¶ 183-184, 189-99). Plaintiffs also creatively recast that same "nondisclosure" claim as a claim "for benefits" under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), on the theory that Aetna's undisclosed internal practices effectively deprived Plaintiffs of what they characterize as a "coverage-benefit" that is "distinct from individual claims for the payment of the medical losses incurred" by plan participants. (Compl. ¶ 204). Plaintiffs pray

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19 Because Plaintiffs' RICO claims would impair Texas's administrative regime and frustrate its declared state policies, this case is very different from that confronted by the Supreme Court in *Humana*, where the only potential conflict between Nevada's insurance law and RICO was the nature of the remedy provided. *See Humana*, 119 S. Ct. at 715 (considering whether "a federal law, which proscribes the same conduct as state law, but provides materially different remedies, 'impair[s]' state law under the McCarran-Ferguson Act"). The state laws implicated by Plaintiffs' RICO claims here do not merely regulate remedies for concededly wrongful conduct. Instead, they address the very core of state insurance regulation: what conduct by an insurer is (or is not) permissible and what rates are (or not) appropriate in light of the services rendered.

that those purported ERISA violations be remedied by injunctive relief and by "restitution" or a "*cy pres* trust" from which putative class members and their counsel will be compensated. (*Id.* at p. 94.)

* * * *

No. 01-10905

In The
United States Court of Appeals
For The Fifth Circuit

JUAN DAVILA,
Appellant

v.

AETNA U.S. HEALTHCARE; INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

BRIEF OF APPELLEES
AETNA U.S. HEALTHCARE INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

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AETNA U.S. HEALTHCARE OF NORTH TEXAS INC.

[Page 4]

* * * *

Nevertheless, Davila purported to allege direct liability claims under the Act against Aetna arising from Aetna's purported refusal to fill a prescription recommended by Davila's treatment physician.[14]

[Page 16]

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. . . . authority from this and other circuits has applied it where (as here) a participant like Davila complains of an adverse utilization review determination. This Court and its sister circuits have recognized that prospective utilization review of medical benefits is an ERISA benefits determination.[41]

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14 1R2-3.

41 *See Thompson*, 202 F.3d at 1073 (upholding removal where precertification rejected for high dose chemotherapy and autologous bone marrow transplant); *Hull*, 188 F.3d at 941 (upholding removal where precertification rejected for thallium stress test); *Danca*, 185 F.3d at 3 (upholding removal where precertification rejected for inpatient psychiatric care); *Bast*, 150 F.3d at 1006 (finding preemption where precertification delayed for autologous bone marrow transplant); *Parrino*, 146 F.3d at 702 (upholding removal where "FHP initially refused to authorize payment for the therapy, claiming it was experimental and unnecessary"); *Turner*, 127 F.3d at 197 (upholding removal where "Transplant Committee . . . concluded . . . that the Duke program had as yet produced no adequate data suggesting a likelihood of success,"); *Jass*, 88 F.3d at 1485 (upholding removal where "Karen Margulis, an agent of PruCare, determined that [physical therapy] was not necessary"); *Cannon*, 77 F.3d at 1271 (upholding removal where "the insurers denied preauthorization for the ABMT); *Toltan*, 48 F.3d at 940 (finding preemption where plaintiff did not receive requested sub-

[Footnote continued on next page]

[Page 31]

Although Davila's Petition is intentionally vague on a great many things, it is clear on one matter: Davila is suing Aetna directly because of a decision that it made, not because of any "mixed eligibility and treatment determination" made by his treating physician. As such *Pegram* is particularly inapplicble, because "mixed eligibility ***and treatment*** determinations"[61] (which Davila continually disguises as "mixed medical decisions" or "mixed medical necessity determinations" or simply "mixed decisions")[62] are determinations made by ***treating physicians***, not independent claims administrators for ERISA plans.

* * * *

[Page 43]

First, the notion that one must resort to legislative history or law review pieces for a nearly 30-year-old federal statute with over 2800 opinions addressing preemption[84] is highly

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[Footnote continued from previous page]

stance abuse and psychiatric care); *Spain*, 11 F.3d at 131 (finding preemption where approval of autologous bone marrow transplant was delayed); *Kuhl*, 999 F.2d at 300 (upholding removal where "Lincoln National refused to precertify payment for the surgery"); *Rodriguez*, 980 F.2d at 1016 (upholding removal where "Rodriguez believed that the attention of an orthopedic specialist was needed, but was stymied in his efforts to obtain a referral letter from Heistand or Pacificare"); *Corcoran*, 965 F.2d at 1324-25 (upholding removal where "despite Dr. Collins's recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care").

61 *Pegram*, 530 U.S. at 231.

62 *See, e.g.*, App. Br. at 12, 13, 20, 30

84 *De Buono*, 520 U.S. at 809 n.1.

suspect. It is especially questionable in the area of benefits administration where Congress's intent is so clear. It is improper to muddy the legal waters with legislative history when the statutory command is clear. *United States v. Gonzales*, 520 U.S. 1, 6 (1997). Likewise, courts "have no authority to enforce [a] principl[e] gleaned solely from legislative history that has no statutory reference point." *Shannon v. United States*, 512 U.S. 573, 584 (1994).

U.S. COURT OF APPEALS FOR THE FIFTH CIRCUIT

Court of Appeals Docket #: 01-10891

RUBY R. CALAD AND WALTER PATRICK THORN,
Plaintiffs,

v.

CIGNA HEALTHCARE OF TEXAS, INC., ET AL.,
Defendants.

DOCKET ENTRIES

7/10/01 Private civil diversity case docketed. NOA filed by Appellant Ruby R Calad. [01-10891] (trm) [01-10891]

8/27/01 Record excerpts filed by Appellant Ruby R Calad in 01-10891 # of copies: 4 Sufficient [Y/N]: y. [01-10891, 01-10943] (rsm) [01-10891 01-10943]

8/27/01 Appellant's Brief filed by Appellant Ruby R Calad in 01-10891. Copies of brief: 7 # of pages: 55. Word count: 12,749 Disk Provided [Y/N]: Y Date of COS: 8/27/01 Sufficient [Y/N]: Y. [01-10891, 01-10943] A/Pet's Brief ddl satisfied. E/Res's Brief due on 9/26/01 for Cigna Healthcare TX in 01-10891. (sep) [01-10891 01-10943]

10/26/01 Record excerpts filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 # of copies: 7

Sufficient [Y/N]: y [01-10891, 01-10943] (sja) [01-10891 01-10943]

10/29/01 Appellee's Brief filed by Appellee Cigna Healthcare TX in 01-10891. Copies of Brief: 8 # of pages: 54. Word count: 12,751 Disk Provided [Y/N]: y Date of COS: 10/26/01 Sufficient [Y/N]: y. [01-10891, 01-10943] E/Res's Brief ddl satisfied. (sja) [01-10891 01-10943]

11/19/01 Cross Appellee's Brief filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant-Cross-Appellee Ruby R Calad in 01-10943. Copies of Brief: 7 # of pages: 26. Disk Provided [Y/N]: y Sufficient [Y/N]: N MISSING CERTIFICATE OF SERVICE, WRONG COLOR COVERS, MISSING SUMMARY OF ARGUMENT. [01-10891, 01-10943] XE/Res brief ddl satisfied. Sufficient Brief due on 12/3/01 for Ruby R Calad in 01-10891, for Ruby R Calad in 01-10943. (sja) [01-10891 01-109431

11/28/01 Appellee's Brief filed by Appellee Walter Patrick Thorn in 01-10943. Copies of Brief: 7 # of pages: 19. Disk Provided [Y/N]: y Date of COS: 11/26/01 Sufficient [Y/N]: y.[01-10943, 01-10891] E/Res's Brief ddl satisfied. (sja) [01-10891 01-109431

11/29/01 Letter referencing reply brief(s) filed as XE brief [3435442-1] by Appellant-Cross-Appellee Ruby R Calad in 01-10891, reply brief(s) filed as EX brief [3435442-1] by Appellant-Cross-Appellee Ruby R Calad in 01-10943, filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, in 01-10943. [3473504-1] [01-10891, 01-10943] (SEND TO SCR. JUDGE AND PANEL) (ksw) [01-10891 01-10943]

11/29/01 Brief made sufficient by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant-Cross-Appellee Ruby R Calad in 01-10943 [01-10891, 01-10943] Sufficient Brief ddl satisfied. Brief okay as filed. See letter filed 11/29/01.

12/11/01 Cross Appellant's Reply Brief filed by Appellee's-Cross-Appellant Aetna U.S. Hlthcare in 01-10891, Appellee-Cross-Appellant Aetn US Hlthcare N in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943, Copies of COS: 12/10/01 Sufficient [Y/N]: y. [01-10891, 01-10943] (sja) [01-10891 01-10943]

5/6/02 Oral argument heard. Case argued by George Parker Young for Appellant Robert Roark; Robert Roark, on behalf of the Estate of Gwen Roark in 01-10831, Robert N Eccles for Appellee Humana HMO Texas Inc, Appellee Humana Health Plan, Appellee Humana Inc in 01-10831, George Parker Young for Appellant-Cross-Appellee Ruby R Calad in 01-10891, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Robert N Eccles for Appellee Cigna Healthcare TX in 01-10891, George Parker Young for Appellant Juan Davila in 01-10905, John Bruce Shely for Appellee Aetna US Hlthcare of North Texas, Appellee Aetna US Hlthcare in 01-10905, George Parker Young for Appellee Walter Patrick Thorn, Appellant-Cross-Appellee Ruby R Calad in 01-10943, John Bruce Shely for Appellee-Cross-Appellant Aetna US Hlthcare of North Texas, Appellee-Cross-Appellant Aetna US

Hlthcare in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (pft) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Opinion filed. Issd in T form? Y Issue Mandate due on 10/8/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943 . [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Judgment entered and filed. [01-10831, 01-10891, 01-10905, 01-10943] (dtg) [01-10831 01-10891 01-10905 01-10943]

9/17/02 Costs taxed - Thorn pays 1/2 costs and defendants pay 1/2 costs. Copies to counsel. [3818848-1] [01-10891, 01-10943] (dtg) [01-10891 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 for rehearing. # of copies filed: 4 [3829883-1]. Issue Mandate ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

9/30/02 Petition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant

Aetna US Hlthcare N in 01-10943 for rehearing en banc. # of copies filed: 20 [3830095-1] Sufficient Rehearing due on 10/11/02 for Aetna US Hlthcare N in 01-10891, for Aetna US Hlthcare in 01-10891, for Aetna US Hlthcare N in 01-10905, for Aetna US Hlthcare in 01-10905, for Aetna US Hlthcare N in 01-10943, for Aetna US Hlthcare in 01-10943. Sufficient [Y/N]: N Missing statement of facts. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/1/02 Petition filed by Appellee Cigna Healthcare TX in 01-10891 for rehearing en banc. # of copies filed: 20 [3831100-1]. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

10/2/02 Rehearing made sufficient by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 [01-10891, 01-10831, 01-10905, 01-10943] Sufficient Rehearing ddl satisfied. (mcs) [01-10831 01-10891 01-10905 01-10943]

10/4/02 Unopposed motion filed by Appellant Robert Roark in 01-10831 for leave to file rehearing out of time [3832947-1] Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (ksw) [01-10831 01-10891 01-10905 01-10943]

10/10/02 COURT Order filed granting the unopposed motion of appellant, Robert Roark, for leave to file

petition for rehearing en banc out of time [3832947-1] in 01-10831, 01-10891, 01-10905, 01-10943. (JES) Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

10/10/02 Petition filed by Appellant Robert Roark in 01-10831 for rehearing en banc. # of copies filed: 20 [3839307-1]. Submit Rehearing due ddl canceled. Sufficient [Y/N]: Y. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

10/24/02 Response requested by the Court to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, Response/Opposition due on 11/4/02 in 01-10831, in 01-10891, in 01-10905, in 01-10943. in 01-10831, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare,

Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc (3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief(s) [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief(s) [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, Appellee Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10943 [01-10831, 01-10891, 01-10905, 01-10943] (ksw) (01-10831 01-10891 01-10905 01-109431

11/4/02 Response/opposition filed by Appellant-Cross-Appellee Ruby R Calad in 01-10891, Appellant Juan Davila in 01-10905, Appellant-Cross-Appellee Ruby R Calad in 01-10943 to petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10831, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N Response/Opposition ddl satisfied in 01-10831, petition for rehearing en banc

[3831100-1] by Appellee Cigna Healthcare TX in 01-10891, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N, in 01-10891, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10905, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcarena, Aetna US Hlthcare N in 01-10905, petition for rehearing en banc [3831100-1] by Appellee Cigna Healthcare TX in 01-10943, petition for rehearing en banc [3830095-1] by Appellee-Cross-Appellant Aetna US Hlthcare, Aetna US Hlthcare N in 01-10943. Sufficient [Y/N]: Y. [4006462-1] [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

11/4/02 Response/opposition filed by Appellee Humana Inc in 01-10831, Appellee Humana Health Pln TX in 01-10831, Appellee Humana HMO Texas Inc in 01-10831 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical

Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N]: Y. [4006487-1] [01-10831, 01-10891, 01-10905, 01-109431 (mcs) [01-10831 01-10891 01-10905 01-10943]

11/4/02 Response/opposition filed by Appellee-Cross-Appellant Aetna US Hlthcare in 01-10891, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10891, Appellee Aetna US Hlthcare in 01-10905, Appellee Aetna US Hlthcare N in 01-10905, Appellee-Cross-Appellant Aetna US Hlthcare in 01-10943, Appellee-Cross-Appellant Aetna US Hlthcare N in 01-10943 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943. Sufficient [Y/N]: Y [4006523-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-109431

11/5/02 Response/opposition filed by Appellee Cigna Healthcare TX in 01-10891 to petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10831, petition for rehearing

en banc [3839307-1] by Appellant Robert Roark in 01-10891, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10905, petition for rehearing en banc [3839307-1] by Appellant Robert Roark in 01-10943, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10831, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10831, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10891, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10891, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10905, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10905, Amicus Curiae supplemental brief [3839619-1] by Amicus Curiae Texas, State of in 01-10943, Amicus Curiae supplemental brief [3852875-1] by Amicus Curiae Amer Medical Assn, TX Medical Assn in 01-10943. Sufficient [Y/N1: Y [4006951-1]. [01-10831, 01-10891, 01-10905, 01-10943] (mcs) [01-10831 01-10891 01-10905 01-10943]

4/15/03 COURT Order filed denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas, Inc's petition for rehearing [3829883-1] in 01-10831, 01-10891, 01-10905, 01-10943, denying Aetna US Healthcare Inc and Aetna US Healthcare of North Texas Inc's petition for rehearing en banc [3830095-1] in 01-10831, 01-10891, 01-10905, 01-10943. With poll (Y/N)?: N. Issue Mandate due on 4/22/03 in 01-10831, in

	01-10891, in 01-10905, in 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-109431
4/15/03	COURT Order filed denying Robert Roark's petition for rehearing en banc [3839307-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943, denying Cigna Healthcare of Texas Incorporated's petition for rehearing en banc [3831100-1] With poll (Y/N)?: N in 01-10831, 01-10891, 01-10905, 01-10943. Copies to all counsel. [01-10831, 01-10891, 01-10905, 01-10943] (lmc) [01-10831 01-10891 01-10905 01-10943]
4/23/03	Mandate issued. Approved BOC Issued (Y/N)?: y [01-10831, 01-10891, 01-10905, 01-10943] Issue Mandate ddl satisfied. (wdc) [01-10831 01-10891 01-10905 01-109431

U.S. DISTRICT COURT
NORTHERN DISTRICT OF TEXAS (DALLAS)

No. CIV. 3:00-cv-02693

RUBY R. CALAD AND WALTER PATRICK THORN,
Plaintiffs,

v.

CIGNA HEALTHCARE OF TEXAS, INC., ET AL.,
Defendants.

DOCKET ENTRIES

Filing Date	No.	Proceedings
12/11/2000	1	NOTICE OF REMOVAL(with state court papers attached); Filing Fee $150 Receipt # 134145 (15+) (lch) (Entered: 12/12/2000)
12/11/2000	1	DEMAND for jury trial made in state court by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn (15+) (lch) (Entered: 12/12/2000)
12/11/2000	2	ANSWER to Complaint by defendant Cigna Healthcare of (6) (lch) (Entered: 12/12/2000)
12/11/2000		PRELIMINARY ASSIGNMENT TO Magistrate Judge Jeff Kaplan (lch) (Entered: 12/12/2000)

Filing Date	No.	Proceedings
* * * * * *		
12/12/2000	4	Joinder and Consent to removal of civil action/RESPONSE by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT in support of [1-1] removal notice (3) (jrb) Modified on 12/14/2000 (Entered: 12/14/2000)
12/12/2000	5	CERTIFICATE OF INTERESTED PERSONS by defendant Cigna Healthcare of (3) (jrb) (Entered: 12/14/2000)
* * * * * *		
01/22/2001	8	MOTION by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to remand (9) (vdf) (Entered: 01/23/2001)
01/22/2001	9	BRIEF by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (vdf) (Entered: 01/23/2001)
01/23/2001	10	APPENDIX by plaintiff Ruby R. Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (vdf) (Entered: 01/23/2001)
* * * * * *		
02/20/2001	13	RESPONSE by defendant Cigna

Filing Date	No.	Proceedings
		Healthcare of in opposition to [8-1] motion to remand (4) (jrb) (Entered: 02/21/2001)
02/20/2001	14	MEMORANDUM by defendant Cigna Healthcare of in support of [13-1] opposition response (15+) (jrb) (Entered: 02/21/2001)
02/20/2001	15	APPENDIX by defendant Cigna Healthcare of in support of [13-1] opposition response (15+) (jrb) (Entered: 02/21/2001)
02/20/2001	16	MEMORANDUM by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT in support of [1-1] removal notice (15+) (jrb) (Entered: 02/21/2001)
* * * * * *		
03/09/2001	19	REPLY by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to response to [8-1] motion to remand. (Cigna) (10)1(jrb) Modified on 03/12/2001 (Entered: 03/12/2001)
03/09/2001	20	REPLY by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn to response to [8-1] motion to remand. (Aetna) (11) (jrb) (Entered: 03/12/2001)
03/09/2001	21	Second APPENDIX by plaintiff

Filing Date	No.	Proceedings
		Ruby R Calad, plaintiff Walter Patrick Thorn in support of [8-1] motion to remand (15+) (jrb) (Entered: 03/12/2001)
* * * * * *		
04/10/2001	28	Supplemental Appendix and RESPONSE by plaintiff Ruby R Calad, plaintiff Walter Patrick Thorn in opposition to [26-1] notice. (15+) (jrb) (Entered: 04/11/2001)
* * * * * *		
04/20/2001		Motion hearing re: [8-1] motion to remand Motion hearing held (cxj) (Entered: 04/23/2001)
04/20/2001	30	Minute order: Motion hearing Held before Senior Judge Barefoot Sanders Court Reporter: Janet Wright (1) (cxj) (Entered: 04/23/2001)
* * * * * *		
06/21/2001	33	MEMORANDUM OPINION AND ORDER. For the foregoing reasons, the Court concludes that Plaintiff Calad's claims were properly removed, and the Motion to Remand is therefore Denied with respect to Calad. As requested in the alternative by Calad, her claims against CIGNA are Dismissed With Prejudice. The

Filing Date	No.	Proceedings
		motion to Remand is Granted with respect to Plaintiff Thorn, and his claims are hereby Remanded to the 162nd. Judicial District Court of Dallas County, Texas. So Ordered. Granting in part, denying in part [8-1] motion to remand. See order for specifics. (Signed by Senior Judge Barefoot Sanders) Copies to counsel: 6/21/01 Page(s): 14 (tem) Modified on 06/21/2001 (Entered: 06/21/2001)
06/21/2001	34	JUDGMENT. It Is Ordered, Adjudged and Decreed by the Court that Plaintiff Calad's Motion to Remand is Denied. Pursuant to Plaintiff Calad's request, her claims are Dismissed with Prejudice. It Is Further Ordered, Adjudged and Decreed by the Court that Plaintiff Thorn's Motion to Remand is Granted, and his claims are Remanded to the 162nd. Judicial District Court of Dallas, County, Texas. (Signed by Senior Judge Barefoot Sanders) Copies to counsel: 6/21/01 Page(s): 1 (tem) (Entered: 06/21/2001)
06/21/2001		Case closed (tem) (Entered: 06/21/2001)
06/26/2001	35	CERTIFIED MAIL executed 6/22/01 [34-1] judgment order, [33-1] order received by the 162nd. Judi-

Filing Date	No.	Proceedings
		cial District Court, 600 Commerce Stree, Dallas, Tx (1) (tem) (Entered: 06/26/2001)
06/27/2001	36	NOTICE OF APPEAL by plaintiff Ruby R Calad re [34-1] judgment order Payment: NO FEE PAID TO Mailed (2) cc:Judge (jmr) Modified on 06/27/2001 (Entered: 06/27/2001)
06/27/2001		Notice of appeal and certified copy of docket to USCA: [36-1] appeal (jmr) (Entered: 06/27/2001)
07/06/2001		USCA appeal fees received $ 105.00 [36-1] appeal Receipt # 152584 (jmr) (Entered: 07/06/2001)
* * * * * *		
07/10/2001	38	NOTICE OF CROSS-APPEAL by defendant Aetna U.S. Healthcare, defendant Aetna U.S. Health NT Filing Fee $ 105.00 Receipt # 152717 TOOC (3) cc: Judge (jmr) Modified on 07/11/2001 (Entered: 07/11/2001)
07/11/2001		Notice of appeal and certified copy of docket to USCA: [38-1] cross appeal (jmr) (Entered: 07/11/2001)
07/12/2001		USCA Case Number, 01-10891 Re: [36-1] appeal USCA received NOA 7/2/01 (jmr) (Entered: 07/13/2001)

Filing Date	No.	Proceedings
* * * * * *		
07/25/2001		USCA Case Number, 01-10943 Re: [38-1] cross appeal USCA received NOA 7/12/01 (jmr) (Entered: 07/26/2001)
07/26/2001		Transmitted record on appeal 2 vol. record, 2 vol. USC, and 1 transcript to U.S. Court of Appeals: [36-1] appeal, [38-1] cross-appeal (jmr) Modified on 07/26/2001 (Entered: 07/26/2001)
04/25/2003	40	Revised Opinion of USCA. Judgment in 01-10831 (3:00cv2368-D), regarding the Roarks, is Affirmed. The judgment in No. 01-10891 (3:00cv2693-H) is REVERSED in regard to Calad and AFFIRMED IN REGARD to Thorn. The judgment in No. 01-10905 (4:00cv1855-Y) is REVERSED in regard to Davila. All these matters are REMANDED to the respective district courts for further proceedings, if any, that may be called for by this opinion in accordance with USCA judgment (certified copy) re [38] Notice of Appeal filed by Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare of North Texas, Inc., 36 Notice of Appeal filed by Ruby R Calad. (jmr) (Entered: 04/25/2003)

Filing Date	No.	Proceedings
04/25/2003	41	REVISED JUDGMENT/MANDATE of USCA Judgment of the District Court is affirmed in part and reversed in part, and the cause is remanded to the District Court for further proceedings in accordance with the opinion of this Court. Thorne pay 1/2 of the costs (on appeal) and defendants pay 1/2 of the costs (on appeal) as to [38] Notice of Appeal filed by Aetna U.S. Healthcare, Inc., Aetna U.S. Healthcare of North Texas, Inc., 36 Notice of Appeal filed by Ruby R Calad. Issued as Mandate: 4/23/03. (jmr) (Entered: 04/25/2003)
04/25/2003	42	BILL OF COSTS from USCA against Roarks (courtesy copy that came with order Docs. 40, 41) . (Entered: 04/25/2003)
* * * * * *		
04/28/2003	43	ORDER: This case is remanded to the 162nd Judicial District Court of Dallas County, Texas, for all further proceedings, in accordance with the Fifth Circuit Mandate. Certified copies of order mailed to all parties and to the District Court by certified mail, return receipt on 5/1/03. (Signed by Judge Barefoot Sanders on April 28, 2003) (jyg,) (Entered:

Filing Date	No.	Proceedings
		04/29/2003)
05/22/2003	44	Certified Mail Executed on May 21, 2003 re: 43 Order remanding to the 162nd Judicial District Court. (jyg,) (Entered: 05/28/2003)
* * * * * *		

CAUSE NO. 00-09041

RUBY R. CALAD AND WALTER PATRICK THORN, Plaintiffs, V. CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants.	IN THE DISTRICT COURT OF DALLAS COUNTY, TEXAS I-162ND JUDICIAL DISTRICT

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE STATE DISTRICT JUDGE:

NOW COMES PLAINTIFFS, Ruby R. Calad and Walter Patrick Thorn, filing this their Original Petition complaining of Cigna HealthCare of Texas, Inc. (d/b/a Healthsource) and Cigna Corporation (collectively "Cigna"); and AEtna U.S. Healthcare, Inc. and AEtna U.S. Healthcare of North Texas, Inc. (collectively "Aetna"), and or cause of action would show as follows:

I. DISCOVERY CONTROL PLAN

1. Discovery is intended to be conducted under Level 3 of Texas Rule of Civil Procedure 190.

II. OVERVIEW

2. This claim is brought pursuant to, the Texas Health Care Liability Act, Tex. Civ. Prac. & Rem. Code §§ 88.001, et seq., complaining of Defendants' wrongful usurpation of

medical necessity determinations from Plaintiffs' treating physicians. In making its determinations as to the medical necessity of treatment recommended by Plaintiffs' own treating physicians. Defendants directly and adversely affected and influenced the quality of the medical diagnosis, care, and treatment provided to Plaintiffs, as more fully described herein.

A. Cigna's Negligent Adherence to its Medial Necessity Criteria Regarding Ruby Calad's Hospital Stay

3. On September 9, 1999, Ruby was admitted to Memorial City Hospital for a hysterectomy with rectal, bladder and vaginal repair. The surgery was to be performed by Cigna's physician, Dr. Estrada. At the time of her admission, Ruby was informed that for the scheduled major surgery, Cigna authorized only *one* day hospital stay as "medically necessary."

4. Despite undergoing this major surgery, Ms. Calad did not qualify under Cigna's medical necessity criteria for continued hospital stay and was unable to incur the expense personally. Despite the recommendations of her own treating physician, Ms. Calad was prematurely forced out of the hospital by Cigna while suffering intense pain treated with strong pain narcotics, unable to sit because of the episiotomy, while taking continuing medications for seizures, posttraumatic stress, unmanageable stress, panic disorder, depression, anxiety and attention deficit disorder. Ms. Calad continues to suffer the effects of this trauma.

B. AEtna's Negligent Delay of Walter Thorn's Medically Necessary Surgical Treatment

5. Walter Patrick Thorn was involved in an auto accident on September 9, 1999, in which he incurred numerous bodily injuries, including a severely injured left hand. His primary care physician, referred Mr. Thorn to an hand specialist, who

determined that Mr. Thom needed immediate surgery to save his hand, and scheduled Mr. Thorn to have surgery on his hand the next day.

6. Only hours before his scheduled surgery, however, AEtna withdrew its pre-approval of the surgery. As a result of this wrongful interference, Mr. Thorn's surgery was needlessly delayed for almost a week. The scarring Mr. Thorn incurred as a result of the delay in the surgery has resulted in reduced mobility of Mr. Thorn's hand.

7. AEtna's preemptive determination of the lack of medical necessity in promptly treating Walter Thorn, despite the recommendations his own treating physicians, directly and adversely affected and influenced the quality of care and treatment provided to Walter Thom, causing Anther injury to Walter Thorn's damaged hand, the effects of which he continues to suffer.

8. This suit is for damages caused by Defendants' wrongful usurption of medical necessity determinations from the Plaintiffs' treating physicians. The Defendants' preemptive determination of the lack of medical necessity in 1) refusing to allow Ms. Calad to stay longer in the hospital,, and 2) refusing to promptly treat Walter Thorn, despite the recommendations of their own treating physicians, directly and adversely affected and influenced the quality of cars and treatment provided to Plaintiffs, resulting in the injuries detailed herein.

III. PARTIES

A. Plaintiffs

9. Plaintiff Ruby R. Calad is an individual residing in Harris County, Texas.

10. Plaintiff Walter Patrick Thom is an individual residing in Palo Pinto County, Texas.

B. Defendants

11. Defendant CIGNA HEALTHCARE OF TEXAS, INC. d/b/a HEALTHSOURCE is a corporation organized under the laws of Texas to engage in the business of insurance. Said Defendant may be served through its designated agent for service of process, CT Corporation System, 350 N. St. Paul, Dallas, Texas 75201 with citation and a copy of this Petition attached thereto.

12. Defendant CIGNA CORPORATION, the parent corporation of Cigna HealthCare of Texas, Inc., is a foreign corporation (a Delaware corporation) that does not maintain a regular place of business or a designated agent for service of process in the State of Texas. Cigna Corporation, acting through its subsidiaries Cigna HealthCare of Texas, Inc. (d/b/a Healthsource) has sufficient contacts with the State of Texas so that, under the Texas Long Arm Statute, Tex, Civ. Prac. & Rem. Code §§ 17.041-17.045, this Court may properly exercise personal jurisdiction, and Cigna Corporation may be served with process by serving the Texas Secretary of State, comporting with due process requirements and without offending traditional notions of fair play and substantial justice. Cigna Corporation's last known home office address for service of process through the Secretary of the State of Texas is: One Liberty Place, 1650 Market Street, Philadelphia, Pennsylvania 19192-1550.

13. Defendant AETNA U.S. HEALTHCARE, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons Freeway, Suite 300, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

14. Defendant AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC. is a Texas corporation doing business in the State of Texas and may be served with process by serving its registered agent of service, Kathryn Bowen, 2777 Stemmons

Freeway, Dallas, Texas 75207 with citation and a copy of this Petition attached thereto.

IV. JURISDICTION AND VENUE

15. Jurisdiction is proper in this Court because the amount in controversy in this case exceeds the jurisdictional limits of State District Courts in Texas.

16. Venue is proper in Dallas County, Texas because both Cigna and AEtna maintain principal offices in Dallas County. See Tex. Civ. Prac. & Rem. Code § 15.002(a)(3).

V. FACTS

A. Cigna's Adverse Influence and Control Over Ruby Calad's Medically Necessary Hospitalization

17. Through her husband's employer, The Ryland Group. Inc. Ryland Homes, Plaintiff Ruby Calad and her husband selected the Cigna Exclusive Provider Program (EPP) medical plan for the coverage and provision of health care services Cigna's EPP plan—an insurance plan, not a self funded plan—is an in network only benefits program providing a national health maintenance organization (IMO) plat Subscribing to the EPP plan, Ruby and her husband chose to become members of Cigna HealthCare of Texas, Inc., a managed care organization which provides health care to individuals throughout Texas.

18. On September 9, 1999, Ruby was admitted to Memorial City Hospital for a hysterectomy with rectal, bladder and vaginal repair to be performed by Cigna's physician, William Joseph Estrada, M.D. Going through pre-authorization and coverage procedures with Cigna, Ruby was informed that for the scheduled major surgery, Cigna authorized only one day for her hospital stay. Dr. Estrada's nurse attempted to reassure Ruby that if the doctor felt Ruby needed to stay longer in the hospital she would stay longer.

19. Decisions regarding health care and discharge from inpatient facilities are not made by the physicians, however, but rather by a Cigna representative—usually a clerk or a nurse, not a licensed physician. It is Cigna which makes medical decisions and manages a patient's health care, and not so much the physicians within the Cigna HealthCare health plan. It was just such a Cigna hospital discharge nurse who insisted on Ruby's traumatic, premature discharge over the advice of Ruby's treating physician.

20. Despite the reassurances of Dr. Estrada's nurse, the stress of undergoing major surgery was compounded by Cigna's authorization, conveyed directly to Ruby, for no more than a single day hospital stay for recovery from the scheduled major surgery. Indeed, this stress and anxiety increased exponentially following the surgery when Ruby's physician, rather than being in charge of managing and coordinating her care, was informed by Cigna's nurse the second day after the major surgery that Ruby must leave the hospital if there was no hemorrhaging, fever, or high blood pressure—unless Ruby wanted to pay $1,500+ per day.

21. Not qualifying under Cigna's criteria for continued hospital stay and unable to incur the expense personally, Ruby suffered further pain and suffering when she was herded out of the hospital. Had Cigna deferred to and relied upon the advice and recommendation of Ruby's treating physician so that he was allowed to manage and coordinate her care, she would have remained in the hospital for additional time to recover from the major, traumatic surgery of the hysterectomy with rectal, bladder and vaginal repair. Instead, Ms. Calad endured needless pain and suffering which resulted in her returning to the hospital via the emergency room only a few days after Cigna's preemptive discharge. By reason of the above and foregoing, Ruby Calad comes now and sues.

B. AEtna's Adverse Influence and Control Over Walter Thorn's Medically Necessary Treatment

22. Plaintiff Walter Patrick Thorn is a resident of Gordon, Texas who receives his AEtna U.S. Healthcare through his employment as a coach for the Azle school district. On September 9, 1999, Mr. Thorn sustained numerous injuries in a car accident, and was flown by helicopter to Harris Methodist Fort Worth Hospital. At the time, the injury of greatest concern was that to his left hand which was severely injured and required the amputation of his ring-finger in the emergency room.

23. Two doctors at the hospital advised Mr. Thorn that another surgery would have to be performed within *two to three days* in order to save the remainder of his hand. The hospital remanded Mr. Thorn to his primary care provider, Dr. Singh, whom ha saw on September 14, 1999. Dr. Singh immediately referred Mr. Thorn to Dr. Harry Orenstein, a specialist and AEtna designated provider for the type of injury he sustained, whom he saw the same day. Dr. Orenstein recommended immediate surgery, and scheduled Mr. Thorn for surgery the next day.

24. On September 15,1999, mere bouts before the scheduled surgery and despite earlier indications that the surgery had been pre approved, AEtna refused to authorize Dr. Orenstein to perform the surgery. The insurer informed the specialist that AEtna would need to review the case before authorizing the surgery, despite the fact that time was of the essence in saving the hand.

25. Dr. Orenstein sent Mr. Thorn to a physical therapist for treatment so that the hand could be kept alive until the surgery was approved by AEtna. On September 21,1999; Mr. Thom's surgery was finally performed. However, the scarring incurred from the delay in the surgery has resulted in reduced mobility of Mr. Thorn's hand.

VI. CAUSE OF ACTION

A. Texas Health Care Liability Claim

26. Plaintiffs hereby incorporate Paragraphs 1 through 25 above, inclusive.

27. This claim is brought pursuant to §§ 88.001, et seq., of the Texas Civil Practices & Remedies Code. As described above, Defendants failed to use ordinary care in influencing, controlling, participating in and making medical necessity decisions regarding the medical treatment of Plaintiffs. Defendants each served as managed care entities exercising control and/or influence over the medical care received by Plaintiffs: By definition, a "managed care entity" includes any entity which delivers, administers, or assumes risk for health care services. See Tex, Civ. Prac. & Rem. Code, § 88.001(8).

28. Medical services were actually provided to Plaintiffs by the Defendants: they controlled, influenced, participated in, and made medical necessity decisions which affected the quality of the diagnosis care, and treatment provided to Plaintiffs, violating the duty of ordinary care set forth in §§ 88.001 and 88.002. Such violation of ordinary care was the proximate cause of Plaintiffs' damages, as described herein.

29. The Defendants, either singularly as the evidence may show, failed during the time in which they were influencing, controlling, participating in, or providing medical necessity decisions within the standard of care for Ruby Calad's need for continued hospitalization and the diagnosis, treatment and rehabilitation of Walter Thorn's injured hand. Additionally, these Defendants put systems in place such as to make such sub-standard care more likely than not.

30. Each and every one of the foregoing acts of omission and commission, taken separately and collectively, constituted the direct and proximate cause of injuries suffered by Plaintiffs. Accordingly, Plaintiffs bring suit for their damages pursuant to §§ 88.001, et seq., of the Tex. Civ. Prac. & Rem. Code. All such actions and inactions by the Defendants with regard to the medical necessity determinations made by Defendants with respect to Plaintiffs' care constitutes negli-

gence that has been the proximate cause of significant damages to Plaintiffs herein.

31. Plaintiffs have fulfilled all requirements of §§ 88.001, et seq., which are prerequisites to this suit Expert reports shall be filed within ninety (90) days of filing of this claim, as required by Tex Civ. Prac. & Rem. Code § 88.002(k). The independent review set forth in § 88.003 was of no benefit prior to filing this suit and is of no benefit now—the harm has already occurred.

VII. DAMAGES

32. Plaintiffs hereby incorporate Paragraphs 1 through 31 above, inclusive.

33. The foregoing acts and omissions, taken separately and collectively, were the direct and proximate cause of the harm caused to Plaintiffs. According Plaintiffs sue for.

Lost earnings, both past and future

Pecuniary loss, both past and future

Physical pain and mental anguish, both past and future

34. Plaintiffs' claims do not seek reimbursement for treatment, medical procedures, or hospitalization; Plaintiffs do not seek to recover for denial of any benefits. Notably, Plaintiffs' injuries cannot be remedied by any retroactive authorization or payment of any benefit. Plaintiffs seek relief based upon the Defendants' failure to use ordinary care in "influencing," "controlling," "participating in," and making medical necessity determinations, where care was actually being provided.

VIII. GROSS NEGLIGENCE/PUNITIVE DAMAGES

35. Plaintiffs hereby incorporate Paragraphs 1 through 35 above, inclusive.

36. Plaintiffs were the victims of a knowing, calculated scheme whereby the Defendants increased their profits by

adversely affecting the medical care for patients such as Ruby Calad and Walter Thom through the Defendants' own decisions regarding medical necessity. The evidence will show that Defendants had both actual and subjective knowledge that their scheme involved a degree of risk which would lead to the serious injury or death of Defendants' members such as Plaintiffs. Nonetheless, Defendants put in place and enforced their system of health care delivery, with conscious indifference to the rights, safety and welfare of others and the injury such a system which would cause. Therefore, Plaintiffs seek punitive damages, pursuant to § 41.001, *et seq.*, of the Texas Civil Practices & Remedies Code, against Defendants.

IX. PLAINTIFF'S CLAIMS FOR DAMAGES NOT BARRED BY ART. 4590i, §§ 11.02-11.04. or CPRC § 41.008

37. Plaintiffs' health care liability claims for damages against Defendants are not barred or limited by the Texas Medical Liability and Insurance Improvement Act, Tex Rev. Civ. Stat Ann. Art. 45901, §§ 11.02, 11.03, and 11.04 (Vernon Supp. 1995)("the Act"), which attempt to limit the maximum liability of physicians and certain health care providers, for medical or health care negligence in malpractice or health care liability claims only for the reasons that:

(a) Sections 11.02(a), 11.03, and 11.04 are arbitrary, unreasonable, and in violation of plaintiffs' rights to due process of law and/or equal protection of the laws under the Fifth and Fourteenth Amendments to the United States Constitution, and Article I, sections 3 and 19 of the Texas Constitution, because (1) the damage limitation invidiously discriminates between seriously injured or death victims of medical or health care negligence or malpractice. (2) the damage limitation grants health care providers special immunity from damages over other tort-feasors, (3) the damage limitation fails to provide a reasonable substitute for

malpractice victims or their heirs who suffer damages in excess of that amount, (4) the damage limitation discriminates between medical malpractice victims and victims of other torts in general, (5) article 4590i and/or the damage limitation did not have a rational basis or was not justified in view of the absence of a so called "medical malpractice crisis" or "medical malpractice insurance crisis," and (6) alternatively, the alleged crisis no longer exists;

(b) Sections 11.02, 11.03, and 11.04 are in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988);

(c) Sections 11.02, 11.03 and 11.04 are in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article I, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages;

(d) Sections 11.02, 11.03, and 11.04 unduly and unnecessarily restrict the plaintiffs' right to deal with the so-called "crisis" in violation of Tex. Rev. Civ. Stat Ann. Art. 4590i, section 1.02(b) & (c); and

(e) Sections 11.02, 11.03, and 11.04 were declared unconstitutional by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988). They are thus dead statutes because they can only be in force and effect if they are passed again, in a constitutional form, by the Texas Legislature. These statutes cannot be "resurrected" by the courts. Thus, sections 11.02, 11.03, and 11.04 are not in force and effect, and do not operate to limit the plaintiffs' damages.

(f) In the alternative, the Defendants are not "providers" under the Act.

(g) In the further alternative, the caps imposed by §§ 11.02, 11.03, and 11.04 apply on a per defendant basis.

38. Further, plaintiffs' claims for exemplary damages against Defendants arc not barred or limited by Texas Civil Practices & Remedies Code § 41.008, which attempts to limit the liability of Defendants for exemplary damages, for the reasons that:

(a) Section 41.008 is in violation of the open courts clause, article I, section 3, of the Texas Constitution for the reasons stated by the Texas Supreme Court in *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); and

(b) Section 41.008 is in violation of plaintiffs' rights of trial by jury under the Texas Constitution, article 1, section 15, because the damage limitation interferes with the plaintiffs' right to a jury determination of the fact issue of their damages.

(c) In the alternative, the caps imposed by § 41.008 apply on a per defendant basis.

X. PREJUDGMENT INTEREST

39. The Plaintiffs also seek prejudgment interest as a matter of law on their damages described herein calculated in accordance with Tex. Rev. Civ. Stat., art. 5069-1.05, or upon such other terms, conditions, and rates as allowed by law.

40. Plaintiffs further request the Court to take judicial notice of the rate of interest published by the Texas Consumer Credit Commission in the Texas Register on the date of judgment in this cause for purposes of calculating the rate of prejudgment interest to be awarded to Plaintiffs in this cause, or such other periods of time, and such other rate or rates of

interest allowed by law for determination of prejudgment interest.

X. DEMAND FOR JURY TRIAL

41. Plaintiffs hereby demands a jury trial of the above entitled and numbered cause. The Plaintiffs are entitled to a trial by jury in the above cause pursuant to the Texas Constitution, Art. I, Section !5, and Tex. R. Civ. P. 216.

42. Plaintiffs sue Defendants jointly and severally.

XII. PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiffs Ruby Calad and Walter Patrick Thom pray that they have judgment against all Defendants named herein, as follows:

(a) That Plaintiffs recover judgment from Defendants for Plaintiffs' actual damages; in a total sum in excess of the jurisdictional limits of this court;

(b) That Plaintiffs recover judgment from the Defendants for exemplary damages, in a total sum in excess of the jurisdictional limits of this court;

(c) That Plaintiffs recover prejudgment interest on the amount accrued on the damage amount(s) at the highest legal rate allowed by law;

(d) That Plaintiffs recover post-judgment interest on the due amount at the highest legal rate from the date of judgment until it is paid;

(e) That Plaintiffs recover all costs of court;

(f) For such other and further relief, at law or in equity, to which they may, show themselves justly entitled.

Respectfully submitted,

__/s/ George Parker Young__

George Parker Young

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ATTORNEYS FOR PLAINTIFFS

IN THE U.S. DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN,	§	
	§	
v.		
	§	CIVIL ACTION NO.
CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE,	§	
CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	3-00CV-2693H
	§	

NOTICE OF REMOVAL

Defendants CIGNA HealthCare of Texas, Inc., d/b/a Healthsource, Cigna Corporation (herein after referred to collectively as CIGNA), file the following Notice of Removal ("Notice").

1. An action was commenced against CIGNA in the 162nd judicial district court of Dallas County, Texas. The action is entitled *Ruby R. Calad and Walter Patrick Thorn, Plaintiffs v. CIGNA Healthcare of Texas, Inc. d/b/a Healthsource, Cigna Corporation, Aetna U.S. Healthcare, Inc.; and Aetna U.S. Healthcare of North Texas, Inc., Defendants*, Cause No. 00-09041, (hereinafter "State Court Action"). The following process, pleadings and orders have been served on CIGNA or have been filed by CIGNA and are attached hereto as exhibits:

A. Plaintiffs' Original Petition

B. Original Answer of AETNA's U.S. Healthcare, Inc. and AETNA U.S. Healthcare of North Texas, Inc.

C. Judge's Docket Sheet

D. Return of citation of CIGNA Healthcare of TX, Inc. d/b/a Healthsource

E. Return of Citation of CIGNA Corporation

F. Return of Citation of Aetna U.S. Healthcare, Inc.

G. Return of Citation of Aetna U.S. Healthcare of N. Texas, Inc.

H. Letters

I. Certified copy of Docket Sheet

2. This Notice is timely brought. Pursuant to 28 U.S.C. 1446(b), this Notice is being filed within 30 days after receipt of the initial pleading (Plaintiff's Original Petition Ex. A) setting forth the Plaintiff's claims.

3. Removal venue is appropriate because the Dallas Division of the Northern District of Texas embraces the place where the State Court Action is pending.

4. Removal is appropriate because plaintiff's state-law claims are all completely preempted by ERISA. Regardless of how artfully plead are the claims, this is nothing more than a "denial of benefits" case. As shown below, Plaintiff's Original Petition focuses on CIGNA's alleged failure to authorize non-covered additional hospital days:[1]

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[1] A plaintiff's pleadings control whether removal is appropriate. *See Brown v. Southwestern Bell Telephone Co.*, 901 F.2d 1250, 1254 (5th Cir. 1990). Plaintiff cannot defeat federal jurisdiction after removal by attempting to change his allegations or re-characterize his claims. *See Lynch Ford, Inc. v. Ford Motor Co.*, 934 F. Supp. 1005, 1007 (N.D. Ill 1996); *Xactron Management*

[Footnote continued on next page]

1). Ms. Calad did not qualify under CIGNA's medical necessity criteria for continued hospital stay and was unable to incur the expense personally. Petition Paragraph 4.

2). Going through preauthorization and coverage procedures with CIGNA, Ruby [Calad] was informed that for the scheduled major surgery, Cigna authorized only one day for her hospital stay. Petition Paragraph 18.

3). Ruby [Calad] did [n]ot [qualify] under CIGNA's criteria for continued hospital stay. Petition Paragraph 21

ERISA provides the *exclusive* remedy for resolution of claims like these.[2]

[Footnote continued from previous page]

Ltd. v. Kreepy Krauley USA, Inc., 697 F. Supp. 1465, 1466 (D. Fla. 1988).

[2] *See* 29 U.S.C. 1001 *et seq.* (§§ 501, 502); *also see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (wrongful denial of benefit payments).

6. Thus, Plaintiff's claims are completely preempted by ERISA and are removable to Federal Court under 28 USC § 1441 as an action arising under Federal law, even though the ERISA-related nature of the action does not appear from the face of the pleading.[3] Therefore, this Court has federal question jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. §§ 1001 *et seq.*

7. As an action of a civil nature found on a claim or right arising under the laws of the United States, this action is removable pursuant to the provisions of 28 U.S.C. 1441(a) and (b).

8. CIGNA has obtained the consent of all co-defendants.

9. Contemporaneous with the filing of this Notice, CIGNA has given the 162nd Judicial District Court of Dallas County, Texas, written notice of the same, a copy of which is attached hereto as Exhibit J.

WHEREFORE, Defendants CIGNA Healthcare of Texas, Inc. d/b/a Healthsource and Cigna Corporation respectfully remove this action to this Court.

Respectfully submitted,

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER

---

[3] *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

By: /s/ Steven R. Shaver
Steven R. Shaver
State Bar No. 18136550
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ATTORNEYS FOR DEFENDANTS CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTH-SOURCE, AND CIGNA CORPORATION

[Exhibits Omitted]

[Exhibit A in Appendix of Evidence Supporting Cigna's Response to Plaintiffs' Motion to Remand]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN, Plaintiffs, v. CIGNA HEALTHCARE OF TEXAS, INC, D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC.; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC., Defendants.	CIVIL ACTION NO. 3:00-CV-2693-H

AFFIDAVIT OF JOHN W. WARGO

STATE OF MARYLAND

COUNTY OF MONTGOMERY

BEFORE ME, on this day, personally appeared John W. Wargo, who, after being duly sworn, deposed and stated as follows:

1. My name is John W. Wargo. I am over the age of twenty one years, have never been convicted of a felony, and am competent to make this affidavit.

2. I am employed by Connecticut General Life Insurance Company ("CGLIC") as the client manager for The Ry-

land Group, Inc. As such, I have personal knowledge of the facts set forth in this affidavit and all of the facts recited herein are true and correct.

3. The Ryland Group, Inc. maintains certain plans through which certain employment benefits, including but not limited to medical and dental benefits, are provided to eligible employees of The Ryland Group, Inc. My responsibilities as the client manager for The Ryland Group, Inc. have included oversight and management of certain benefit plans provided by The Ryland Group, Inc. pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). By virtue of my job responsibilities, I am familiar with the terms, conditions and operations of these benefit plans.

4. One of the benefit plans maintained by The Ryland Group, Inc. provides medical benefits to its eligible employees and their dependents. In 1999, the plan was called the Flexible Benefits Program of The Ryland Group, Inc. (the "Plan"). The Plan was and is maintained by The Ryland Group, Inc. for the purpose of providing for its participants or their beneficiaries medical, surgical and hospital care or benefits.

5. Upon establishing the Plan, The Ryland Group, Inc. prepared and issued to eligible employees a summary plan description which described the terms of and benefits provided under the Plan. A true and correct copy of the plan description is attached to my affidavit as Exhibit 1.

6. In 1999, CGLIC was a delegated administrative responsibilities for the Plan. CIGNA HealthCare of Texas, Inc. ("CIGNA HealthCare") is an affiliate of CGLIC. CIGNA HealthCare performed various administrative functions in connection with the Plan in Texas, including providing utilization review services. CIGNA HealthCare was also responsible for reviewing claims for benefits and making benefit determinations. Benefit payments under the Plan were

funded by The Ryland Group, Inc. Medical benefits coverage under the Plan was provided to employees and their dependents on a contributory basis. As such, employees who were enrolled for coverage under the Plan contributed to the cost of the Plan through individual payroll deductions. The Plan is an employee welfare benefit plan subject to ERISA.

7. At all times relevant to this lawsuit, Ruby Calad's spouse was employed by The Ryland Group, Inc. He and his wife, Ruby Calad, were covered under the Plan at the time of Ms. Calad's surgery in September 1999.

8. The documents attached to my affidavit are records of acts, events, conditions, or opinions, made at or near the time, by or from information transmitted by a person with knowledge of the acts, events or conditions. The documents are kept in the course of the regularly conducted business of CGLIC and/or CIGNA HealthCare and it is their regular business practice to make such records.

9. I have reviewed the above statements and they are true, complete and correct.

FURTHER AFFIANT SAYETH NOT.

/s/ John W. Wargo

John W. Wargo

SUBSCRIBED AND SWORN TO before me this 16th day of February, 2001.

SEAL

/s/ Carolyn Brown
Notary Public

[Exhibit 1 to Affidavit of John W. Wargo]

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When you select a participating provider, this plan pays a greater share of the costs than if you were to select a non-participating provider. Participating providers include physicians, hospitals and other health care professionals and facilities. Consult your Physician Guide for a list of participating providers in your area. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs.

Services Available In Conjunction With Your Medical Plan

The following several pages describe helpful services available in conjunction with your medical plan. You can access these services simply by calling the toll free number shown on the back of your ID card. These services are provided by Intracorp, a CIGNA Company and can help ensure that you and your covered Dependents benefit fully from your medical coverage.

For example;

- Through **CIGNA's toll free care line**, you can talk to a trained registered nurse who will help answer general benefit questions and will provide you with the names of participating providers in your area and in other cities should you require medical care while away from home.
- **Case Management** services help individuals with short term and catastrophic medical conditions by offering appropriate treatment options which meet the patient's needs and keep costs manageable.

You are encouraged to maximize the benefits under your medical plan by taking advantage of these important services.

CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line is a medical advisory service provided through Intracorp., a CIGNA company. You can talk to a Registered Nurse (RN) during normal business

hours, Monday through Friday simply by calling the toll free number shown on your ID card. All calls are confidential. CIGNA's toll-free care line RNs can help answer general benefit questions, such as questions regarding pre-admission certification, and can provide assistance in locating physicians, hospitals and other health care services.

CIGNA's toll-free care line personnel can also provide you with the names of participating providers. If you or your dependents need medical care, you may consult your Physician Guide which lists the participating providers in your area or call CIGNA's toll-free number for assistance. And, if you or your dependents need medical care while away from home, you may have access to a national network of participating providers through CIGNA's Away From Home Care feature. Call CIGNA's toll-free care line for the names of participating providers in other network areas. Whether you obtain the name of a participating provider from your Physician Guide or through the care line, it is recommended that you call the provider to confirm that he or she is a current participant in the CIGNA Preferred Provider Program prior to making an appointment.

CIGNA's toll-free care line personnel cannot answer specific questions about your medical coverage or claims, provide medical opinions, comment on the competency or reputation of a provider, prescribe medication, give diagnoses or advice about treatment. You may be referred to an appropriate resource for questions related to these topics.

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management

arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Intracorp Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up to date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the **toll free care fine number** shown on the back of your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

2. Intracorp assesses each case to determine whether Case Management is appropriate.

3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of an extended hospital convalescence.) You are not penalized it the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)

6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

IMPORTANT INFORMATION

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY THE RYLAND GROUP, INC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL. ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

THE SCHEDULE

MEDICAL BENEFITS—GENERAL

The Medical Benefits Plan offered by your Employer includes two options. These options are: (1) the Exclusive Provider Medical Benefits (Option I), and (2) the Comprehensive Medical Benefits (Option II).

You and your Dependents may enroll for only one of the options not for both options.

The sections of this certificate entitled "Exclusive Provider Medical Benefits" apply to coverage under Option I. The sections of this certificate entitled "Comprehensive Medical Benefits" apply to coverage under Option II. All other sections of the certificate apply to coverage under each of the options unless stated otherwise.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

To receive Exclusive Provider Medical Benefits, you and your Dependents must pay a portion of the expense for services and supplies. That portion is the Copayment. Refer to the Copayment section of The Schedule for more information.

Guest Privileges

If you or one of your Dependents will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for Exclusive Provider Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in

connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth. Please review this Plan for further details on the specific coverage available to you and your Dependents under this Plan.

Contract Year

Contract Year means a period from January 1st to December 31st in each calendar year.

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

Maximum Benefits	
For You and Your Dependents	**This Plan Will Pay;**
Lifetime Maximum Benefit	Unlimited
Inpatient Mental Illness Maximum	30 days per Contract Year
Inpatient Alcohol and Drug Abuse Maximum	30 days per Contract Year
External Prostheses Maximum	$1,000 per Contract Year
Skilled Nursing Facility Maximum	60 days per Contract Year
Outpatient Rehabilitative Therapy Maximum	60 consecutive days per condition
Daily Limits	
Hospital Bed and Board Daily Limit	The Hospital's negotiated daily rate
Skilled Nursing Facility Daily Limit	The Skilled Nursing Facility's negotiated daily rate
Hospice Bed and Board Daily Limit	The Hospice Facility's negotiated daily rate

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents
Copayments

The Emergency Service Copayment and the Provider Service Copayment are as follows:

Emergency Service/Copayment

The plan covers authorized Emergency Services. You and your Dependent pay the Emergency Care Copayment shown below. For information on Emergency Services, including any waiver provisions and restrictions refer to the section entitled "Exclusive Provider Medical Benefits."

Emergency Care Copayment for:

Physician's Office	$5 per visit
Emergency Room	$50 per visit

Provider Service Copayment

Office Visit	
Maternity	$0 for initial visit to confirm pregnancy only
Surgical Procedures	No Charge
Other (except for any services shown below)	$5 per visit
Infertility	
Office Visit for Diagnosis	$20 per visit
Surgery	$200 per surgery
Outpatient Rehabilitative Therapy	$5 per visit
Hospital Confinement for Mental Illness, Alcohol and Drug Abuse, (other than detoxification only)	$25 per day

THE SCHEDULE

EXCLUSIVE PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Provider Service Copayment (Cont.)

Outpatient Mental Illness (other than Group Therapy)	
First 20 Visits per Contract Year	$10 per visit
Visits 21-30 per Contract Year	$20 per visit
Outpatient Group Therapy for Mental Illness	$10 per visit
Outpatient Alcohol and Drug Abuse:	
First 20 Visits per Contract Year	$10 per visit
Visits 21-40 per Contract Year	$20 per visit
Visits 41-60 per Contract Year	$25 per visit

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents	This Plan Will Pay;
Lifetime Maximum Benefit	Unlimited
Maximum Benefits	
Inpatient Mental Illness Maximum (Calendar Year)	30 days
Inpatient Alcohol and Drug Abuse Maximum (Calendar Year)	30 days
Outpatient Mental Illness Maximum (Calendar Year)	30 visits $10 per visit for the first 20 visits. $20 per visit for the next 10 visits.
Outpatient Alcohol and Drug Abuse Maximum (Calendar Year)	60 visits, $10 per visit for the first 20 visits. $20 per visit for the next 20 visits. $25 per visit for the last 20 visits.
Home Health Care Maximum	40 visits per calendar year

COMPREHENSIVE MEDICAL BENEFITS (Cant.)

For You and Your Dependents	**This Plan Will Pay;**
Covered Expense Daily Limit	
Participating Provider Hospital	The Hospital's negotiated rate
Non Participating Provider Hospital	The Hospital's most common daily rate for a semiprivate room
Participating Provider Hospice Facility	The Hospice Facility's negotiated rate
Non Participating Provider Hospice Facility	The Hospice Facility's most common daily rate for a semiprivate room
Skilled Nursing Facility	The Skilled Nursing Facility's most common daily rate for a semiprivate room, for up to 60 days in a calendar year

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Deductibles

The Deductibles listed below are expenses to be paid by an Employee or a Department for the services rendered. These Deductibles are in addition to any other expenses incurred for which no benefits are payable because of any coinsurance factor.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and are not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Participating Provider Office Visit Copayment	$5, then the Plan pays 100%
First visit to confirm pregnancy	
Delivery charges (including subsequent prenatal and postnatal visits)	100%, subject to deductible
Immunizations, Allergy injections	$5 or the actual charge, whichever is less, then the Plan pays 100% of any balance
All other Office Visits	$5, then the Plan pays 100%*

*This copay is waived for mammography

Comprehensive Medical Deductibles (waived for Participating Provider expenses)	$1,000
Family Deductible	$3,000

After Comprehensive Medical Deductibles totaling $3,000 have been applied in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Comprehensive Medical Deductibles for the rest of that year.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Coat.)

For You and Your Dependents

Benefit Percentage

The Benefit Percentage for Covered Expenses incurred for charges made by a Participating or a Non Participating Provider is as follows.

	Participating Provider	Non Participating Provider
Outpatient Mental Illness, Alcohol and Drug Abuse	100%	50%
Emergency Services	100%	100%*
Well Child Care	100%	Not Covered
Well Woman Care	100%	Not Covered
Annual Routine Physical Exams (including immunizations)	100°io	Not Covered
Mammograms	100%	50 %, after the deductible
All Other Covered	100%	50%

*This is the same Benefit Percentage as for Participating Provider charges.

The Benefit Percentages above for Physician and professional services will be based on allowed charges.

Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth. Please review this Plan for further details on the specific coverage available to you and your Dependents under this Plan.

THE SCHEDULE

MEDICAL CARE BENEFITS

For You and Your Dependents

PAC/CSR REQUIREMENTS. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependents for each inpatient Hospital admission. CSR should be requested prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include:

- the first $300 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission;

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR;

- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

MEDICAL CARE BENEFITS
For You and Your Dependents

PAC/CSR REQUIREMENTS (Continued)

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

THE SCHEDULE

CIGNA TRADITIONAL DENTAL
For You and Your Dependents

HOW YOUR DENTAL PLAN WORKS

Class I Preventive Care	Plan pays 100% There is no Deductible	
Class II Basic Restorative	You or your Dependent pays $50 Deductible	Play pays 80%
Class III Major Restorative		Play pays 60%
Class IV Orthodontia		Play pays 50%
Class V TMJ		Play pays 60%

Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.

Maximum Benefit

Classes I, II, III Combined
Calendar Year Maximum $1,600

THE SCHEDULE

Class IV
Lifetime Maximum $1,500

Class V
Lifetime Maximum $750

Individual Deductible $50

A person must satisfy this deductible amount for each calendar year before Dental Benefits are payable.

Family Deductible $100

After Dental Deductibles totaling $100 have been applied in a calendar year for either (a) you and your Dependents; or (b) your Dependents; your family need not satisfy any further Dental Deductibles for the rest of that year.

SECTION 125 PLAN

Your Employer has agreed to provide benefits according to Section 125 of the Internal Revenue Code. A Section 125 plan is a written group Insurance plan which allows Employees a choice among two or more benefits consisting of salary (cash) and nontaxable benefits. Non-taxable benefits may be in the form of salary reduction. Therefore, normally taxable salary remains Employer money and is put toward benefits tax free.

Because your group insurance plan is a Section 125 plan, certain provisions of this certificate are superseded as described below.

No Longer in Active Service

If you return to Active Service within the same benefit plan year following your termination of employment. Section 125

plan provisions supersede the "Eligibility - Effective Date" section under the "Eligibility For Employee Insurance" provisions of your certificate as follows.

a. If your insurance ceases due to your termination of employment, your Employer may allow you to become insured again for your previously selected benefits upon your return to Active Service.

Termination of Insurance Due to Failure to Pay Premium

If you fail to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the "Eligibility Effective Date" section under the "Eligibility For Employee Insurance" provisions of your certificate as follows;

b. If your insurance ceases due to your failure to pay required premium, unless you are not in Active Service due to qualified leave of absence under the Family and Medical Leave Act of 1993, you will not be permitted to elect any coverage until the next Open Enrollment Period.

In addition, due to failure to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the "Eligibility Effective Date" section under the "Late Entrant Employee' provisions of your certificate as follows;

c. You may not enroll as a Late Entrant by providing evidence of good health, if your coverage terminates due to cancellation of your payroll deduction. You are not considered enrolled in the group insurance plan. You will not be able to select group insurance coverage until the next benefit plan year.

Change in Family Status

Due to a change in your family status, which changes your coverage needs, you may be eligible to change your benefits. Section 125 plan provisions supersede the "Eligibility Effective Date" section under the eligibility For Employee Insurance" provisions in your certificate as follows:

- You may be eligible to change your original selection of benefits when a change in your family status occurs. Consult your Employer for details.

SECTION 125 PLAN

Transfer Provisions

Section 125 plan provisions supersede the "Eligibility Effective Date" section under "For Dental Insurance—Employees Change in Option Elected" provisions as follows;

d. You may not transfer to another Option at any time prior to the next Open Enrollment Period.

Section 125 plan provisions supersede the "Important Information About Your Dental Plan" section under "Change in Option Elected in Addition to Open Enrollment" provisions as follows;

- You may not transfer to another Option at any time prior to the next Open Enrollment Period.

HOW TO FILE YOUR CLAIM

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required

will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card certifies that you are insured and tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical or Dental Expenses

The first Medical or Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS;

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER (2242852) WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

ELIGIBILITY EFFECTIVE DATE

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if

- you are in a Class of Eligible Employees; and
- you are an eligible, full time Employee; and
- you normally work at least 40 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of;

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: First day of the calendar month coinciding with or next following the Employee's date of hire.

New Employee Group: First day of the calendar month coinciding with or next following the Employee's date of hire

Classes of Eligible Employees

All Regularly Scheduled Full Time Employees

ELIGIBILITY—EFFECTIVE DATE

Employee Insurance

This Plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees in writing to insure you, provided that the effective date of your Medical Insurance will not be contingent upon evidence of good health. For plans which do not include a Pre existing Condition Limitation, you may be required to wait until the next plan enrollment period to elect coverage if you apply as a Late Entrant.

If you are not in Active Service on the date you would otherwise become insured, you will become insured on the date you return to Active Service.

Late Entrant Employee

You are a Late Entrant if;

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of good health at your expense it you are a Late Entrant. This Late Entrant provision will not apply to Medical Insurance.

ELIGIBILITY EFFECTIVE DATE

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the pay you become eligible for De-

pendent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees in writing to insure that Dependent, provided that the effective date of Medical Insurance will not be contingent upon evidence of good health. For plans which do not include a Preexisting Condition Limitation. You may be required to wait until the next plan enrollment period to elect coverage if you apply as a Late Entrant.

Your Dependents will be insured only if you are insured.

Late Entrant Dependent

You are a Late Entrant for Dependent Insurance if;

- you elect that insurance more than 30 days after you became eligible for it; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of your Dependent's good health at your expense if you are a Late Entrant. This Late Entrant provision will not apply to Medical Insurance.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth it you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for; (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child as soon as reasonably possible.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements;

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and

4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

When you elected Medical Insurance for yourself and your Dependents, you elected one of the two options provided by this Plan;

- Exclusive Provider Medical Benefits (Option I), or
- Comprehensive Medical Benefits (Option II)

Details of the benefits under each of the options are described in the following pages. Refer to the section entitled "Exclusive Provider Medical Benefits" or "Comprehensive Medical Benefits" depending on the option you elected.

When electing an option initially or when changing options as described below the following rules apply;

- You and your Dependents may enroll for only one of the options, not for both options.
- Your Dependents will be insured only if you are insured and only for the same option.

Changing Options

Change In Option Elected:

You may elect to change options for yourself and your Dependents during any Open Enrollment Period.

In addition, if you and your Dependents are insured under Option I, you may elect to transfer to Option II at any time if: 1) you relocate outside the Provider Organization's service area, or 2) you are deemed to be terminated for cause under Option I as determined by the Provider Organization.

Effective Date of Change In Option;

You are required to complete a new enrollment form for the option you elect. If you have done so, the effective date for the change in option is as follows:

If you are changing options during an Open Enrollment Period, you and your Dependents will become insured for the option elected on the first day of the month after the end of that Open Enrollment Period.

If you are transferring from Option I to Option II due to relocation or termination for cause, you and your Dependents will become insured for Option 11 on the date you relocate or are terminated.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

Effective Date of Change in Option: (Cont.)

However, if you are not in Active Service on the date you

and your Dependents would otherwise become insured for the option elected, the insurance under that option will become effective on the date you return to Active Service. (This provision will not apply in the case of a transfer to Option II due to termination for cause.)

You and your Dependents' insurance under the prior option will terminate on the same date that the insurance under the option elected is effective.

Open Enrollment Period

Open Enrollment Period means the period in each calendar year from October 1st to October 31st.

Primary Care Physician/Option I Only

Choice of Primary Care Physician;

When you elect insurance under Option I, you will select a Primary Care Physician for yourself and your Dependents from a list provided by the Provider Organization. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility;

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another through the Provider Organization. Any such transfer will be effective on the first day of the month following the month in which the Provider Organization completes

the processing of the change request.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.

DIRECT ACCESS FOR OB/GYN SERVICES:

Female insureds covered by this plan are allowed direct access to a licensed/certified participating practitioner for covered ob/gyn services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the participating practitioner of your choice for pregnancy, well woman gynecological exams, primacy and preventive gynecological care, and acute gynecological conditions.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses or any other expenses described below. CG wilt pay an amount determined as follows for the expenses so incurred after deducting the applicable Provider Service Copayment shown in The Schedule from the expenses incurred for the service received;

100% of the Covered Expenses incurred for charges for Emergency Services provided that; (a) the Emergency Services are received from or pre authorized by the person's Primary Care Physician; or (b) the Emergency Services are not so preauthorized, but are authorized by the Provider Organization after receipt of timely notice, within 48 hours of admission in the case of Hospital Confinement or as soon as reasonably possible. Before benefits are payable, the applicable Emergency Care Copayment shown in The Schedule will be deducted from such Covered Expenses, except that the Emergency Room Copayment

will be waived if the person becomes Confined in a Hospital due to that Injury or Sickness;

100% of any other Covered Expenses incurred for charges made by, or authorized care arranged by, a Participating Provider;

100% of the expenses incurred for vision and hearing screenings provided by the Primary Care Physician for persons age 17 and under;

100% of the expenses incurred for charges made by a Participating Provider for: (a) routine care of a newborn Dependent child prior to discharge from the Hospital nursery; (b) routine physical examinations; and (c) immunizations.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

No Exclusive Provider Medical Benefits are payable unless the services or supplies are recommended by and received from, or approved by, Participating Providers and are authorized by the person's Primary Care Physician and the Provider Organization, except in the case of Emergency Services as specified herein. In the case of mental illness, alcohol or drug abuse treatment, other than Hospital Confinement solely for detoxification, authorization by the Primary Care Physician will be waived.

Payment of benefits will be subject to the Maximum Benefit Provision and to the Mental Illness, Alcohol and Drug Abuse Maximums.

Maximum Benefit Provision

The total amount of benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

Mental Illness, Alcohol and Drug Abuse Maximums

The total number of days for which benefits are payable for

expenses incurred in any Contract Year while a person is Confined in a Hospital due to mental illness, alcohol or drug abuse will not exceed any Inpatient Maximums as shown in The Schedule for those causes. Hospital Confinement solely for detoxification does not count toward any such maximum.

The total number of visits for which benefits are payable for expenses incurred in any Contract Year due to mental illness, alcohol or drug abuse while a person is not Confined in a Hospital will not exceed any Outpatient Maximums as shown in The Schedule for those causes. Visits for treatment of mental illness which qualify as group therapy do not count toward any maximum number of visits shown in The Schedule for mental illness.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies: except that for any day of Hospital Confinement. Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.

- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

- charges made by a Free Standing Surgical Facility, on its own behalf for medical care and treatment.

- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Skilled Nursing Facility Limit shown in The Schedule; nor will benefits be payable far more than the maximum number of days shown in The Schedule.

- charges made by a facility licensed or certified to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.

- charges made by a facility licensed or certified to furnish treatment of alcohol and drug abuse on its own behalf for care and treatment provided on an outpatient basis.

- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

- charges made by a Home Health Care Agency for the following medical services and supplies, provided under the terms of a Home Health Care Plan for the person named in that plan;

- part time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

- part time or intermittent services of a Home Health Aide;

- physical occupational, or speech therapy;

- medical supplies; Durable Medical Equipment used by a person in the course of rendering covered home health care services; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility.

Covered Expenses do not include charges made by a Home Health Care Agency for;

- home health care visits in excess of any applicable Home Health Care Agency Limit shown in The Schedule (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit);

- care or treatment which is not stated in the Home Health Care Plan;

- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;

- a period when a person is not under the continuing care of a Physician.

- charges made for a person who has been diagnosed as having six months or fewer to live due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program;

- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room. Covered Expenses will not include that

portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;

- by a Hospice Facility for services provided on an out patient basis;

- by a Physician for professional services;

- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;

- for path relief treatment, including drugs, medicines and medical supplies;

- by a Home Health Care Agency for;

  - part time or intermittent nursing care by or under the supervision of a Nurse;

  - part time or intermittent services of a Home Health Aide;

  - physical, occupational and speech therapy;

  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses;

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;

- for any period when you or your Dependent is not under the care of a Physician;

- for services or supplies not listed in the Hospice Care Program;
- for any curative or life prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

EXCLUSIVE PROVIDER MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for expenses incurred;

- for or in connection with cosmetic surgery unless (a) a person receives an Injury, while insured for these benefits, which results in bodily damage requiring the Surgery; or (b) it qualifies as reconstructive surgery performed on a person following the surgery, and both the surgery and the reconstructive surgery are essential and medically necessary.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except as otherwise specified in this section. However, Covered Expenses will include the purchase of the first pair of contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or penodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an injury to sound natural teeth sustained while a person is insured for these benefits; or (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgi-

cal Facility or the outpatient department of a Hospital in connection with surgery.

- for transsexual surgery, including hormonal therapy.
- for routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court ordered, forensic or custodial evaluations.
- for which benefits are not payable according to the "General Limitations" section; except that the following will not apply to this section: (a) limitations with respect to a maximum for multiple surgical procedures, an allowable charge for an assistant surgeon or co-surgeon and covered providers being family members; (b) the limitation, if any, with respect to a Dependent child under 15 days old; and (c) any certification or second opinion requirements shown in The Schedule.

Covered Expenses will not include and no payment will be made for expenses incurred;

- for rehabilitative therapy by a licensed physical occupational or speech therapist on an outpatient bass, which is provided for any one condition more than 60 consecutive days after the date of the first such treatment for that condition;
- for charges made by a Physician for the diagnosis or outpatient treatment of structural imbalance, distortion or subluxanon of the vertebrae, except for outpatient rehabilitative therapy within 60 consecutive days per condition;
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation;

- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for penile prostheses;
- for organ procurement costs that are not directly related to procurement of an organ from a cadaver or a donor having a blood relationship with the recipient;
- for penile prostheses;
- for prescription drug charges incurred while not confined in a Hospital, except as noted in the Covered Expenses section;

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents

If, while insured for these benefits, you or any one of your Dependents incurs Covered Expenses. CG will pay an amount determined as follows;

> The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, after deducting any Comprehensive Medical Deductible shown in The Schedule from the Covered Expenses first incurred for a person in each calendar year.

Payment of any benefits will be subject to: (a) any applicable deductibles and maximum benefits shown in The Schedule; (b) the Maximum Benefit Provision; and (c) any Mental Illness, Alcohol and Drug Abuse Maximums.

COMPREHENSIVE MEDICAL BENEFITS

Full Payment Area -For Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $1,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $2,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a Participating Provider during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred by a Participating Provider for or in connection with mental illness, alcohol or drug abuse will not be increased by the terms of this section.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible if not yet satisfied, will continue to apply until it is satisfied.

Full Payment Area - For Non Participating Provider Expenses

When a person has incurred Out-of-Pocket Expenses of $3,000 in a calendar year, benefits for him for Covered Expenses incurred for charges made by a non Participating Provider during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $6,000 in a calendar year, benefits for you and all of your Dependents for Covered Expenses incurred for charges made by a non-Participating Provider

during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred by a non-Participating Provider for or in connection with mental illness, alcohol or drug abuse will not be increased by the terms of this section.

All benefit deductibles will continue to apply. Any Comprehensive Medical Deductible, if not yet satisfied will continue to apply until it is satisfied.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by both Participating and non Participating Providers for which no payment is provided because of any Copayments, any Comprehensive Medical Deductible (including any benefit deductibles) and the coinsurance factor.

COMPREHENSIVE MEDICAL BENEFITS

Maximum Benefit Provision

The total amount of Comprehensive Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

Inpatient Mental Illness, Alcohol and Drug Abuse, Maximums (Calendar Year)

The total number of days for which benefits are payable for all expenses incurred in any calendar year while a person is Confined in a Hospital due to mental illness or due to alcohol or drug abuse will not exceed any separate Inpatient Maximums as shown in The Schedule for those causes.

Outpatient Mental Illness, Alcohol and Drug Abuse Maximums (Calendar Year)

The total number of visits for which benefits are payable or the maximum amount payable for ail expenses incurred in any calendar year due to mental illness or due to alcohol or

drug abuse while a person is not Confined in a Hospital will not exceed any separate Outpatient Maximums as shown in The Schedule for those causes.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.

- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.

- charges made by a Free Standing Surgical Facility, on its own behalf, for medical care and treatment.

- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion which is more than the Skilled Nursing Facility Limit shown in The Schedule.

- charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.

- charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.

- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse for professional nursing service.

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational, or speech therapist; prosthetic appliances; dressings; and drugs and medicines lawfully dispensed only upon the written prescription of a Physician while a person is confined in a Hospital, excluding vitamins.

- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.

- charges made by a Participating Provider for visits for routine preventive (Well-Child) care of a Dependent child during the first tow years of that Dependant child's life, including immunizations.

- charges made by a Participating Provider for: (a) an annual routine physical examination and; (b) immunizations.

- charges made by a Participating Provider for an annual routine Well-Woman examination.

- charges made by a Physician for an annual routine mammogram.

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan;

    - part time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

    - part time or intermittent services of a Home Health Aide;

    - physical, occupational, or speech therapy;

    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for;

- home health care visits during a calendar year, in excess of the Home Health Care Maximum shown in The Schedule. (To determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);

- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made due to Terminal illness for the following Hospice Care Services provided under a Hospice Care Program;
- by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
- by a Hospice Facility for services provided on an out patient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by a Home Health Care Agency for;

- part time or intermittent nursing care by or under the supervision of a Nurse;
- part time or intermittent services of a Home Health Aide;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses;

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

COMPREHENSIVE MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include and no payment will be made for, expenses incurred;

- for or in connection with cosmetic surgery unless; (a) while insured for these benefits, a person receives an injury, which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your Dependents who is less than 16 years old.

- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.

- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an Injury to sound natural teeth sustained while a person is insured for these benefits; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.

- for which benefits are not payable according to the "General Limitations" section; except that the limitations with respect to a maximum for multiple surgical procedures and an allowable charge for an assistant surgeon or cosurgeon will not apply to charges made by a Participating Provider.

COMPREHENSIVE MEDICAL BENEFITS

Common Accident

It you and one or more of your insured Dependents or it two or more of your insured Dependents are injured in the same accident and incur Covered Expenses for those injuries in the calendar year in which the accident occurs, not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred for them during the

rest of that calendar year.

Multiple Birth

Not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred in a calendar year for two or more of your Dependents born in a multiple birth if those Covered Expenses are incurred in the same calendar year in which they are born and are due to;

- premature birth;
- abnormal congenital condition; or
- injury which is received or Sickness which starts not more than 30 days after their birth.

DENTAL BENEFITS OPTION II

For You And Your Dependents

If you or any one of your Dependents incurs Covered Expenses, CG will

- deduct any Dental Deductible that applies from the Covered Expenses first incurred in a calendar year for a person; and
- pay for the other Covered Expenses incurred in that calendar year up to the Maximum Covered Expense determined from the Dental Services Schedule for each Dental Service subject to the Alternate Benefit Provision.

The Dental Deductible is shown in The Schedule.

Missing Teeth and Late Entrant Limit

The amount payable is 50% of the amount otherwise payable for a Class III or Class IV Dental Service in the case of a Late Entrant. No payment will be made for first replacement of teeth that are missing when a person becomes insured for these benefits.

If a person transfers from Option I directly to Option II,

credit will be given for the length of time he was insured under Option I.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics during a person's lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Payments for Comprehensive Full Banded Orthodontic Treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3 month period. In determining the first installment, CG assigns 25% of the charge for the entire course of treatment to the appliance. The rest of such charge is prorated over the estimated duration of such treatment. These payments are made only for services performed while a person is insured.

If insurance or treatment on a person ceases during a period, the amount payable for that period will be prorated.

Maximum Benefit Provision

The total amount payable for all expenses incurred for other than Orthodontics for a person in a calendar year will not be more than the Maximum Benefit shown in The Schedule.

DENTAL BENEFITS OPTION II

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred for such charges when the Dental Service;

- is performed by or under the direction of a Dentist;

- is essential for the necessary care Of the teeth; and
- starts and is completed while the person is insured for Option II.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule is not included.

A Dental Service is deemed to start when the actual performance of the service starts except that;

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

If a person insured for Option II transfers directly to Option I after a Dental Service for fixed bridgework, full or partial dentures, a crown (inlay or onlay) or root canal therapy starts, but before it is completed, the benefits for that Dental Service when performed by the Dentist who started it will be provided under Option II until it is completed. No benefits will be provided for that Dental service under Option I.

Alternate Benefit Provision

When more than one Dental Service could provide suitable treatment based on common dental standards, CG will determine the Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed

Covered Expenses. For this reason, CG strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your dentist know in advance what the benefit plan will cover before any treatment begins.

DENTAL BENEFITS – OPTION II

Predetermination of Benefits

The term Predetermination of Benefits means a review by CG of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to CG before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CG.

The expenses that will be included as Covered Expenses will be determined by CG and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CG will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

DENTAL SERVICES SCHEDULE

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. CG may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to CG.

CG will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

A temporary Dental Service is included in the allowance for the final Dental Service and is not a separate Dental Service.

Dental Service

CLASS 1 SERVICES Diagnostic and Preventive

The Maximum Covered Expense for any Class I Service is 100% of the Reasonable and Customary Charge.

Clinical oral examination - Only two per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any X ray taken in connection with such treatment is a separate Dental Service.)

X-rays - Complete series - Only one per person, including Panoramic film, in any 3 calendar years.

Bitewing X-rays - Only two charges per person per calendar year.

Panoramic (Panorex) X-ray - Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) - Only two per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 19 years old. Only one per person per calendar year.

Topical application of sealant per tooth, on a posterior tooth for a person less than to years old. Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral Limited to non orthodontic treatment.

DENTAL SERVICES SCHEDULE

CLASS II SERVICES - Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

The Maximum Covered Expense for any Class II Service is 80 % of the Reasonable and Customary Charge.

Amalgam Filling - Primary (Baby) Teeth, One Surface

Amalgam Filling - Permanent Teeth, One Surface

Composite/Resin Filling, One Surface

Root Canal Therapy - Any X-ray test laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery - Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service.

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

Periodontal Scaling and Root Planing - Entire Mouth

Adjustments - Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not separate Dental Service.

Recement Bridge

Simple Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine post operative care for extractions and other oral surgery are part of the allowance for each Dental Service.

General Anesthesia - The administration of a general anesthetic is a Dental Service covered by this Schedule only: (a) when medically necessary in conjunction with oral or dental surgery; and (b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

DENTAL SERVICES SCHEDULE

CLASS III SERVICES Major Restorations Dentures and Bridgework

The Maximum Covered Expense for any Class III Service is 60% of the Reasonable and Customary Charge.

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive canes or fracture, cannot be restored with amalgam, composite/resin, silicate acrylic or plastic restoration.

Crowns

Porcelain Fused to High Noble Metal

Full Cast High Noble Metal

Three Fourths Cast, Metallic

Fixed or Removable Appliances

Complete (Full) Dentures, Upper or Lower Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps. rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

This Plan will permit a person who is eligible, but is not covered, under this Plan to be enrolled for its health care coverage when his health care coverage under another Plan ends if: (1) he is not eligible at that time for the other Plan, or a Plan which replaces it; and (2) his enrollment is made within 31 days after the later of: (a) the date his coverage under the other Plan ends; or (b) any continuation period elected by or for him under the other Plan ends.

If that person is enrolled for this Plan before the end of the 31 days, there will be no interruption of coverage. However, coverage under this Plan will be subject to the same requirements, except for postponement due to Active Service or Confinement that would have applied if he had been enrolled on the later of: (1) the date he was first eligible; or (2) the date he last became covered under this Plan. Credit will be given under any Preexisting Condition Limitation from the later of (1) or (2).

RIGHT OF REIMBURSEMENT

The Policy does not cover

(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the

Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG (or the Health-Plan) under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

PAYMENT OF BENEFITS

To Whom Payable

All Medical and Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

It any person to whom benefits are payable is a minor or, in the opinion of CG's not able to give a valid receipt for any payment due him. Such payment will be made to his legal guardian. If no request far payment has been made by his legal guardian. CG may, at its option make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives, spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Bridge Ponacs - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Abutment Crowns - Resin with High Noble Metal

Abutment Crowns - Porcelain Fused to High Noble Metal

Abutment Crowns - Full Cast High Noble Metal

CLASS IV SERVICES Orthodontics

The Maximum Covered Expense for any Class IV Service is 50% of the Reasonable and Customary Charge. Each month of active treatment is a separate Dental Service.

Orthodontic work up including X-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance

Active treatment per month after the first month

Fixed or Removable Appliances Only one appliance per person.

For Tooth Guidance - one arch per person

To Control Harmful Habits - one appliance per person

CLASS V SERVICES Temporomandibular Joint Dysfunction

The Maximum Covered Expense for any Class V Service is 60% of the Reasonable and Customary Charge. Only the Dental Services listed below will be considered covered expenses for the treatment of Temporomandibular Joint Dysfunction:

- Office Visit Adjustment to Appliance
- No more than 6 adjustments in 6 consecutive months after seating or placement of appliance.
- Transcutaneous Electro neural Stimulation

- No more than 4 treatments in a 6 month period.
- Trigger Point Injection of Local Anesthetic into Muscle Fascia
- No more than 4 treatments in a 6 month period.
- Mandibular Orthopedic Repositioning Appliance Only one appliance per person in any 5 year period.

DENTAL BENEFITS EXCLUSIONS

Services Not Covered

Covered Dental Services under Option I and Covered Expenses under Option II will not include and no payment will be made for:

- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a hospital;
- services performed solely for cosmetic reasons;
- any replacement of a bridge, crown or denture which is or can be made functional according to common dental standards;
- replacement of a lost or stolen appliance;
- services excluded according to the "General Limitations" section.

In addition, Dental Benefits under Option I and Option It will be reduced so that the total payment under the items below will not be more than 100% of the charge for the Dental Service if benefits are provided for that service under;

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by the Policyholder.

Covered Dental Services under Option I will not include or, where applicable, no payment will be made for;

- procedures, appliances or restorations whose main purpose is to: (a) change vertical dimension; or (b) diagnose or treat conditions or dysfunction of the temporomandlbular joint except as specified in the Patient Charge Schedule;
- prescription drugs; and sedation or a general anesthesia;
- procedures or appliances for minor tooth guidance;
- treatment rendered by a pedodontist on your Dependent child, who has reached seven years of age; however, an exception may be made due to medical reasons;
- replacement of fixed or removable prosthodontic appliances made useless due to patient abuse, misuse or neglect;
- any procedure or service associated with the placement or prosthodontic restoration of a dental implant.

DENTAL BENEFITS EXCLUSIONS

Services Not Covered

Covered Expenses under Option II will not include, and no payment will be made for. expenses incurred for;

- replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- procedures, appliances or restorations (except full dentures) whose main purpose is to; (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain or acrylic veneers on crowns or pontics on or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semi precision attachments; or splinting,
- a surgical implant of any type including any prosthetic device attached to it;
- instruction for plaque control oral hygiene and/or diet as separate services.

GENERAL LIMITATIONS
MEDICAL AND DENTAL BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents;

- for or in connection with an Injury arising out of, or in the course of any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military service connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;

- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled; "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
- to the extent of the exclusions imposed by any certification requirement or second opinion requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time; the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/ 2 of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the Surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase of replacement of contact lenses except as specifically provided under "Exclusive Provider Medical Benefits"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to Comply with;

- a "no fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

MEDICARE ELIGIBLES

The Medical and/or Dental Expense Insurance for:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 18 months;

will be modified where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under;

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated. All of the benefits from this plan are subject to Coordination of Benefits except those medical services authorized by the Provider Organization which are identified on a list available from the Provider Organization.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules determine its benefits after this Plan.

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated. **Coverage under this Plan plus another Plan will not guarantee 100% total reimbursement.**

The benefits that would be payable for a person from this Plan in the absence of Coordination of Benefits for expenses incurred in any Claim Determination Period will be reduced by the benefits payable for those expenses from all other Plans.

When the benefits from a Plan are in the form of services not cash payments the reasonable cash value of each service will be deemed to be a benefit paid. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would be based on its rules, determine its benefits after this Plan.

COORDINATION OF BENEFITS

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services; (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage

under any labor management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room are medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

COORDINATION OF BENEFITS

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom clam is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that; (a) if the other Plan does not have this rule its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(4) When the above rules do not establish the Order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that;

(a) The benefits of a Plan which covers the person as a laid off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid off or retired employee, or his dependent.

(b) It the other Plan does not have the rule in item (4)(a) which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

COORDINATION OF BENEFITS
Unrestricted Enrollment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to; (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

TERMINATION OF INSURANCE EMPLOYEES

Your insurance will cease on the earliest date below;

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month coinciding with or next following the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends due to temporary layoff or for more than 6 months past the date your Active Service ends if due to leave of absence.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness,

your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Medical Insurance)

If your Active Service ends because you retire, your medical insurance will be continued. If you are less than age 65 and insured under Option I on the date you retire, your insurance will be continued under Option I until you attain age 65. Your insurance will continue under Option II as of your 65th birthday. However, in no event will your insurance be continued past the date in which your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement (for Dental Insurance)

If your Active Service ends because you retire, your dental insurance will be continued until the date in which your Employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance

with the rules of your Employers group health plans) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by CG for you and/or your Dependents, as applicable beyond the earliest of the following dates;

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your Dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to quality as a Dependent.

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date nonce of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates;

- 36 months from the date of (1), (2) or (3) above which ever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your De-

pendent would lose coverage because of an event described in (1), (2), or (3) of Section 8, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18 month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18 month continuation period as ether the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

To be eligible you or your Dependent must;

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following

the determination and within the initial 18 month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29 month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and 8 which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 16, 29 or 36 month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, or a period of time not to exceed the longer of; (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided;

- the required premium is paid; and

- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if;

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act

of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

MEDICAL BENEFITS EXTENSION

Any expense incurred within one year after a person's Medical Expense Insurance ceases will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if because of an Injury or a Sickness;

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness;

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

DENTAL BENEFITS EXTENSION

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if;

- for fixed bridgework and full or partial dentures, the final impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.

- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.

- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

- for Orthodontic Services the treatment commenced while the person was insured and the expenses are incurred within 60 days after his insurance ceases.

There is no extension for any Dental Service not shown above.

SUMMARY PLAN DESCRIPTION

The name of the Plan is;

Flexible Benefits Program of The Ryland Group, Inc.

The Employer's address is;

11000 Broken Land Parkway, Columbia MD 21044

Employer Identification Number (EIN)	Plan Number
52-0849948	506

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA Healthplan, Inc.

The name, address, ZIP code and business telephone number of the Plan Administrator is;

The Ryland Group, Inc. 11000
Broken Land Parkway Columbia MD 21044

The name, address and ZIP code of the person designated as agent for the service of legal process is;

The Ryland Group, Inc. 11000
Broken Land Parkway Columbia MD 21044

Service of legal process may also be made upon a Plan Trustee (if any).

Plan Year

The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each twelve month period which ends on: October 9th.

SUMMARY PLAN DESCRIPTION

Statement of Rights

The following statement of ERISA rights is required by Federal law and regulations to be included in this Plan document;

As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. This law called ERISA, provides that all Plan Participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and Plan descriptions.

- obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator and asking for them. The Administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant under the Plan with a copy of this summary financial report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in the interest of other Plan Participants and beneficiaries.

The law provides that no one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you will receive a written notice, explaining why your claim was denied. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the documents and pay up to $100 a day until you receive them unless they were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may ask the U. S. Department of Labor for help, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. It you lose, the court may order you to pay these costs and fees, for example if it finds your claim frivolous.

If you have any questions about this statement or about your rights under ERISA, you should get in touch with the nearest Area Office of the U.S. Labor Management Services Administration of the Department of Labor.

If you have any questions about your Plan, you should see your Plan Administrator.

DEFINITIONS

Active Service

You will be considered in Active Service;

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a fulltime basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employers scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness. alcohol or drug abuse). Custodial Services include, but shall not be limited to;

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as; (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DEFINITIONS

Dependent

Dependents are;

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old.
  - 19 years but less than 25 years old, enrolled in school as a full time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25. Students as defined above, will also include those who perform Mormon missionary work.
  - 19 or more years old and primarily supported by you and incapable of self sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term child means a child born to you, adopted or in the process of adoption, and a stepchild, regardless of whether the stepchild lives with the Employee, if the Employee has a

legal obligation to support the child or any other child for whom the Employee is the legal guardian.

The term spouse also includes an individual who the Employee has lived with in a common law marriage for at least 2 years in a state where common law marriage is recognized.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

A dependent's insurance will cease at the end of the calendar month coinciding with or next following the date a dependent ceases to meet the definition of a Dependent, except that dependent children and students who reach the limiting age or graduate from college terminate at the end of the calendar year coinciding with or next following loss of eligibility.

DEFINITIONS

Durable Medical Equipment

The term Durable Medical Equipment means equipment which;

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Emergency Services

Emergency Services are medical, surgical, Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness which if not treated immediately, may result in serious medical com-

plications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Provider Organization, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

Employee

The term Employee means a full time employee of the Employer. The term does not include employees who are part-time or temporary or who normally work less than 40 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DEFINITIONS

Free Standing Surgical Facility

The term free standing Surgical Facility means an institution which meets all of the following requirements:

- It has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x ray facilities;
- it has equipment for emergency care;
- It has a blood supply;
- It maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and

- It is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a nonprofit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;

- is run according to rules established by a group of professional persons;

- maintains clinical records on all patients;

- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hos-

pital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

DEFINITIONS

Hospice Care Program

The term Hospice Care Program means:

- a coordinated interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;

- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;

- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;

- is accredited by the National Hospice Organization;

- meets standards established by CG; and

- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which; (a) maintains on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24 hour service by Registered Graduate Nurses;

- an institution which qualifies as a hospital a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or

- an institution which; (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DEFINITIONS

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is;

- a registered bed patient in a Hospital upon the recommendation of a Physician; or

- Partially Confined for treatment of; (a) mental illness; (b) alcohol or drug abuse; or (c) other related illness. To determine benefits payable, two days of being Partially Confined in a Hospital will be equal to one day of being confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24 hour period.

Injury

The term Injury means an accidental bodily injury.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N.," or "L.V.N."

DEFINITIONS

Participating Provider

The term Participating Provider means;

- an institution, facility, agency or health care professional which has contracted directly or indirectly with CG.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Employer.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider to general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

Provider Organization

The term Provider Organization refers to a network of Participating Providers.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is; (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is; (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DEFINITIONS

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if;

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and seventy of the Injury or Sickness being treated will be considered.

Sickness For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy Expenses incurred for routine Hospital

and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in;

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

[Exhibit B in Appendix of Evidence Supporting Cigna's Response to Plaintiffs' Motion to Remand]

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S-660: Hysterectomy, Vaginal, with or without Oophorectomy
CPT-4: 58145, 58260, 58262, 58263, 58267, 58270, 58275, 58280
ICD-9: 68.59
ICD-9: 218.X, 219.X, 221.0, 221.1, 618A

Case Management: Coordinate Care & Anticipate Needs

Preoperative: Hysterectomy is the most common major surgical procedure among women during their reproductive lives. Other options for menorrhagia include medical therapy, endometrial resection, and endometrial ablation. Other options for myomata include medical therapy and myomectomy. The vaginal approach to hysterectomy produces fewer complications and faster recovery than the abdominal approach. The majority of benign enlarged uteri can be resected vaginally, sometimes utilizing morcellation. Laparoscopic assistance is generally unnecessary.

Ensures patient education about postoperative pain management and recognition of postoperative complications. Assesses home safety, needs, and capabilities.

Day of Surgery: Ensures adequate recovery from anesthesia and pain control for discharge. Coordinates multiple caregivers as appropriate.

Home: May require home nursing contact for failure of oral pain control, reinforcement of education, or skilled assessment of complications or comorbidities.

Discharge Status Following Medical Care

Acute: Discharge on day 2; afebrile; bowel sounds present; passing flatus; diet as tolerated; pain control with oral or parenteral analgesic; postoperative nursing visits may be advantageous if oral hydration and nutrition have been marginal; bowel functions has been slow to return; or if the patient has difficulty with ambulation.

Home Care Treatment Plan

V-RN-1 Initial visit on the day of discharge or the next day to:

A. provide clinical assessment including hemodynamic stability, vaginal drainage, and bladder function

B. provide superficial wound care and observe for signs of infection

C. assess medication compliance/need/ knowledge

1. pain control by oral or parenteral analgesics (*See Home Pain Management Guidelines*)

2. evaluate that patient has all prescriptions as ordered, knows how to take them, and understands all common side effects

D. continue patient education

1. discuss limitations in lifting and gradual increase in activities

E. assess nutritional status

1. supplemental intravenous hydration and nutrition can be provided for one to two days

T/V-RN-2 Telephone followup or possible visit on the second or third day at home to:

A. assess pulmonary toilet and overall clinical status

B. provide superficial wound care

C. assess medication compliance/need/knowledge

D. continue patient education

E. assess and support nutritional status as needed

Discharge

Comfort level achieved; skin integrity maintained; tissue perfusion maintained; patient understands need to avoid prolonged sitting and heavy lifting.

IN THE U.S. DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

RUBY R. CALAD AND WALTER PATRICK THORN,	§	
Plaintiffs,	§	
v.	§	Case No.
	§	3-00CV-2693H
CIGNA HEALTHCARE OF TEXAS, INC. D/B/A HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC; AND AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	
Defendants.	§	

PLAINTIFFS' REPLY TO CIGNA'S RESPONSE TO PLAINTIFFS' MOTION TO REMAND

* * * *

[Page 2]

. . . If this Court proceeds to deny Plaintiffs' Motion to Remand, it should also dismiss Ruby Calad's claims *sua sponte* in order to permit this matter to be immediately appealed since Ms. Calad will not be amending to add ERISA claims for benefits.

* * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

RUBY R. CALAD and WALTER PATRICK THORN,	§	
Plaintiffs,	§	Case No. 3-00-CV-2693 H
v.	§	Plaintiffs' Supplemental Appendix And Response to Aetna's Notices of new Preemption Authority
CIGNA HEALTHCARE OF TEXAS, INC. d/b/a/ HEALTHSOURCE, CIGNA CORPORATION, AETNA U.S. HEALTHCARE, INC. and AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.,	§	
Defendants.	§	

PLAINTIFFS' SUPPLEMENTAL APPENDIX AND RESPONSE TO AETNA'S NOTICES OF NEW PREEMPTION AUTHORITY

* * * *

[EXHIBIT 2: Aetna Inc. and Aetna U.S. Healthcare Inc.'s Memorandum of Law in Opposition to Plaintiffs' Motion for Class Certification, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

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* * * *

The precise presentations made to health plan members about the scope of "medically necessary" care available to them vary considerably, and in ways that must be considered material under plaintiff's legal theory. (*See* Popik Decl. ¶¶ 26-31; *see also* Deposition of Julie G. Zyla ("Zyla Dep.") at 102-06.) Some derive from decisions made by individual employers with respect to the form and substance of disclosures; some derive from different CGLIC practices and disclosures from area to area and over time; and some derive from unique requirements of state law.[16]

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16 *See, e.g.*, Fla. Stat. § 409.913(1)(c) (2000) ("'Medical necessity' or 'medically necessary' means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain, or suffering, or results in illness or infirmity . . . provided in accordance with generally accepted standards of medical practice."); Ga. Code. Ann. § 33-20A-31(5) (2000) ("medically necessary care" is "care based upon generally accepted medical practice" that is (1) :[a]ppropriate and consistent with the diagnosis," (2) compatible with national "standards of acceptable medical practice," (3) "[p]rovided in a safe and appropriate setting," (4) "[n]ot provided solely for the convenience" of enrollee, provider or hospital, and (5) :[n]ot primarily custodial care"); La. Rev. Stat. § 22:657(D)(3)(e) (Supp. 2000) ("medically necessary" services are those "recommended for appropriate treatment or care in accordance with nationally accepted current medical criteria"); Minn. Stat. § 62L.02 (subd. 21) (1999) ("'Medical necessity' means the appropriate and necessary medical

[Footnote continued on next page]

[EXHIBIT 3: CIGNA Corporation, CIGNA Health Corporation and Connecticut General Life Insurance Company's Memorandum of Law in Opposition to Plaintiff's Motion for Class Certification, *In re Humana Inc., Managed Care Litigation*, MDL No. 1334 (S.D. Fla. 2000)]

* * * *

[Page 33]

State law is an important variable because HMOs and other managed care products are heavily regulated by the states, although the form of each state's regulation—*i.e.*, the types of disclosures it requires and the limitations it imposes—varies substantially. (*See* Wagener Decl. ¶ 3; Zyla Decl. ¶ 5 ("The applicable state law is also important in determining the information the member receives."); *see also* Zyla Dep. at 31).[18]

[Footnote continued from previous page]

and hospital services eligible for payment under a health benefit plan as determined by a health carrier."); N.C. Cent. Code § 26.1-04-03(17) (1999) ("Medically necessary" services are those that "a reasonably prudent physician or other health care provider would provide to a patient" that are (1) consistent with "generally accepted standards of medical practice," (2) "clinically appropriate," and (3) "not prohibited from establishing its own "definition of 'medically necessary care' for determining which services are covered by the health plan"); S.D. Admin. R. 20:06:21:08 (2000) ("When 'medically necessary' is used as a condition to qualify for benefits, it may not be defined more restrictively than as requiring the certification of the . . . .

* * * *

18 The many variations in state disclosure laws mean that plaintiff's claim cannot be typical of those of putative class members from other states, and that common questions would not predominate. *Andrews*, 95 F.3d at 1025 (RICO claims unsuitable for class

[Footnote continued on next page]

* * * *

[Footnote continued from previous page]

action because problem with trying individualized elements of plaintiffs' claims . . . .

* * * *

[Excerpt from Record in CA5]

SUMMARY PLAN DESCRIPTION

The name of the Plan is:

Flexible Benefits Program of The Ryland Group, Inc.

The Employer's address is:

11000 Broken Land Parkway, Columbia, MD 21044

Employer Identification Number (EIN)	Plan Number
52-0849948	506

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA Healthplan, Inc.

The name, address, ZIP code and business telephone number of the Plan Administrator is:

The Ryland Group, Inc. 11000 Broken Land Parkway
Columbia, MD 21044

The name, address and ZIP code of the person designated as agent for the service of legal process is:

The Ryland Group, Inc. 11000 Broken Land Parkway
Columbia, MD 21044

Service of legal process may also be made upon a Plan Trustee (if any).

Plan Year

The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each twelve-month period which ends on:

October 9th

NO. 01-10891

In The United States Court of Appeals
For The Fifth Circuit

RUBY R. CALAD,
Plaintiff-Appellant-
Appellee,

and

WALTER PATRICK THORNE,
Plaintiff-Appellee,

v.

CIGNA HEALTHCARE OF TEXAS, INC. d/b/a
Healthsource and CIGNA CORPORATION,
Defendant-Appellees,

and

AETNA U.S. HEALTHCARE, INC. and
AETNA U.S. HEALTHCARE OF NORTH TEXAS, INC.
Defendant-Appellants.

Appeal From the United States District Court
for the Northern District of Texas, Dallas Division

BRIEF OF APPELLEES CIGNA HEALTHCARE OF TEXAS, INC. AND CIGNA CORPORATION

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APPELLEES

October 26, 2001

[Page 3]

* * * *

Following the surgery, Calad did not meet the established criteria for extended hospitalization under her plan. 1R-7, 11-12. (Calad concedes that she "did not qualify under CIGNA's medical necessity criteria for continued hospital stay.") Although her treating doctor allegedly recommended that she remain hospitalized, Calad admits that she was unable or unwilling to pay for an extended hospital stay herself. 1R-7, 12. Accordingly, she was discharged from the hospital one day after her surgery. 1R-7, 11-12.

* * * *

[Page 6]

That CIGNA's benefit determination involved an evaluation of "medical necessity" in the administration of the plan does not remove Calad's claim from the scope of ERISA preemption.

* * * *

[Pages 22-23]

C. Under Well-Established Controlling Precedent, Calad's Claim in this Case Arises from a Benefit Determination

Despite her steadfast protestations that her claim is a purely state law claim which should not be preempted by ERISA, Calad's complaint stems entirely from a pre-surgery determination regarding the scope of benefits that would be provided to her under the plan. Calad's allegations against CIGNA include the following:

CIGNA "negligent[ly] adhered to its medical necessity criteria" by authorizing only one day of hospitalization as medically necessary following Calad's surgery (1R-7);

Calad "did not qualify under CIGNA's medical necessity criteria for continued hospital stay and was unable to incur the expense personally" and "[n]ot qualifying under [CIGNA]'s criteria for continued hospitalization," she was "unable to incur the expense personally" (1R-7, 12);

during "pre-authorization and coverage procedures," CIGNA authorized one day of hospitalization following surgery (R-11); and

CIGNA "put in place and enforced their system of health care delivery" in a manner which was consciously indifferent to her rights, safety and welfare (1R-15).

CIGNA made a determination regarding whether extended hospitalization was "medically necessary" following Calad's surgical procedure in its role as the administrator of an ERISA plan. The decision was based entirely upon the scope of benefits available to Calad under the plan according to plan criteria.

* * * *

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The "mixed treatment decision" in *Pegram* also presented a conundrum that is not present in this case. In *Pegram*, the doctor responsible for making medical treatment decisions was simultaneously responsible for making administrative determinations regarding the scope of coverage under the plan. Because the doctor wore two "hats," separating the treatment decision from the coverage determination was virtually impossible.

* * * *

[Page 53]

Finally, CIGNA does not argue that treatment decisions made by a treating doctor should be preempted by ERISA; clearly, they are not. But this case involves no treatment decision. In this regard, Calad's repeated assertion that the field of health care is a subject of traditional state regulation is irrelevant in this case. Calad has no complaint about the care she received from Dr. Estrada. Her complaint stems from her dissatisfaction with the determination made by CIGNA in its administration of the plan. Health care is a subject of state regulation; plan administration is governed by ERISA.

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